

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06435

06432

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>7620 Gough Street</b>	
3. NAME OF DECEASED (Type or print) First <b>WADE</b> Middle <b>BERTIE</b> Last <b>ADAMS</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>8TH</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/13/98</b>
9. AGE (In years lost birthday) yrs. <b>68</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Anchor Post</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Tunbridge, Vermont</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL K. ADAMS</b>		14. MOTHER'S MAIDEN NAME <b>IDA TUCKER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>216-16-67-65</b>	
17. INFORMANT <b>Clinical Records, VAH, Fort Howard, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>COR PULMONALE</b> DUE TO 4344 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 4</b> , 19 <b>66</b> , to <b>May 8</b> , 19 <b>66</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 8</b> , 19 <b>66</b> , and that death occurred at <b>6:15AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Raul de Castro</i>		22b. DATE SIGNED <b>5/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>RAUL DE CASTRO, M.D.</b>		22d. ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/11/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>CONNELLY FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>MAY 11 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Chesapeake Manor Nursing Home</u>						d. STREET ADDRESS <u>8162 Loch Raven Blvd.</u>					
3. NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>J.</u> Last <u>Altomare</u>						4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 12, 1898</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Jerome Duda</u>						14. MOTHER'S MAIDEN NAME <u>Pauline Duane</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>220-24-0535</u>		17. INFORMANT <u>Joseph J. Altomare</u> Address <u>522 Henry St.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 433-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic condition - vascular disease</u> (c) <u>20 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1966</u> to <u>May 1, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 18, 1966</u> , and that death occurred at <u>1:20 p.m.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>S. Elliott Harris</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>S. Elliott Harris</u>						22d. ADDRESS <u>8100 Harford Rd. Balto. 34, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>5-5-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>				
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>						25a. REC'D BY REGISTRAR <u>MAY 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

John W. Smith

1870



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and may event within 72 hours after death.

VR A15ME (5)  
6M 1/66

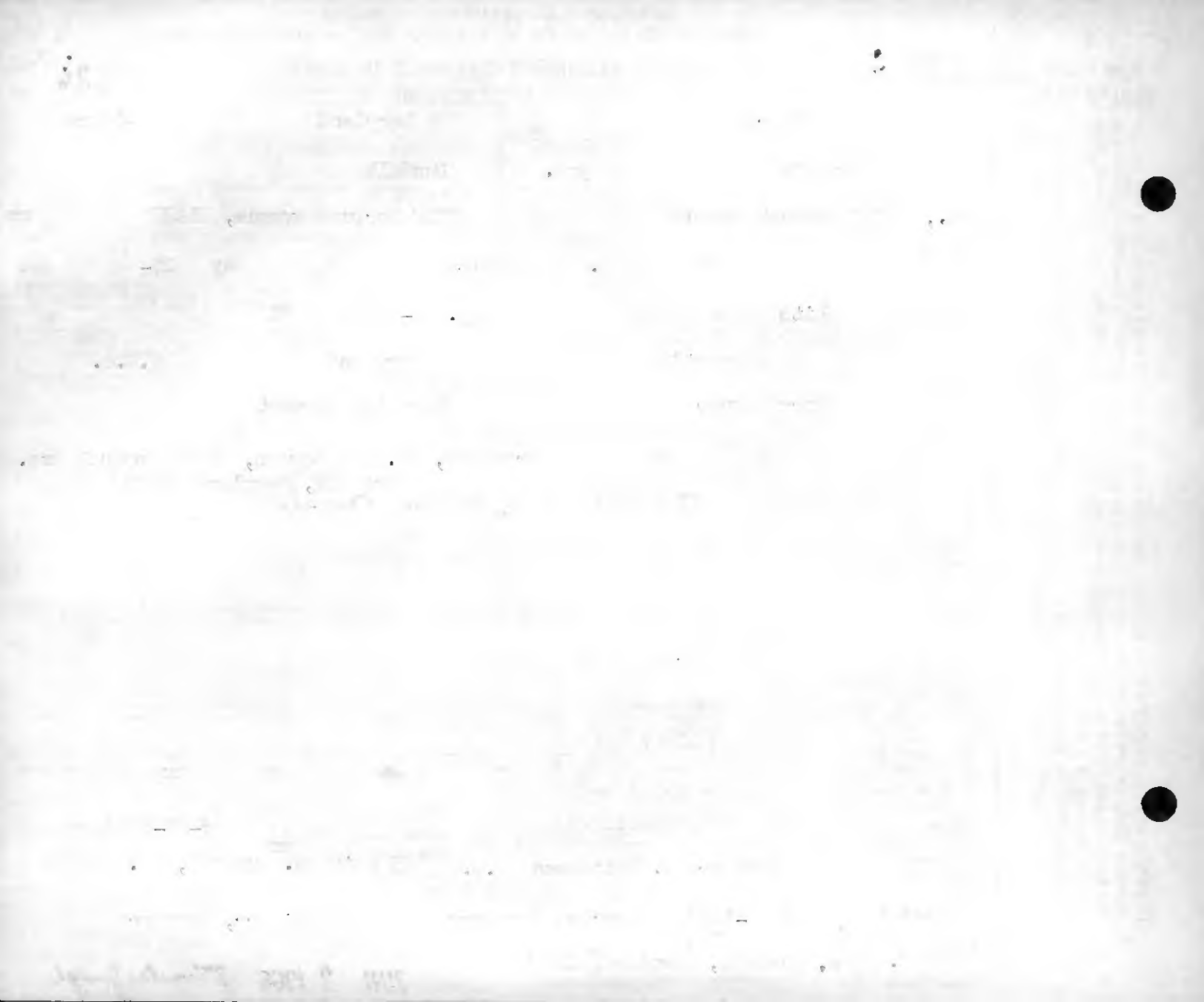
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06437

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06434

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN lb <b>10 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 7710 Norbush Avenue</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>M.</b> Last <b>ALVATER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 28- 1883</b>
9. AGE (In years last birthday) <b>82</b>		10. IF UNDER 1 YEAR Months <b>03</b> Days <b>1</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) <b>Maryland</b>		13. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
14. FATHER'S NAME <b>Henry Gegner</b>		15. MOTHER'S MAIDEN NAME <b>Carolina Rehmert</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. SOCIAL SECURITY NO. <b>No</b>	
18. INFORMANT <b>Grandson, Mr. Lee Bowers, 7721 Norbush Ave.</b>		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Rheumaty</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theodore C. Patterson</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Theodore C. Patterson M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE THEREOF <b>May 30-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>		ADDRESS	
25a. REC'D BY REGISTRAR <b>JUN 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06438									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7 Talbott Avenue</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> d. STREET ADDRESS <u>7 Talbott Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Eldon Willard Amos</u>					4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4, 1907</u>		9. AGE (In years last birthday) <u>58</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Thomas Amos</u>					14. MOTHER'S MAIDEN NAME <u>Lilly May Bull</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-05-2094</u>		17. INFORMANT <u>Family records</u>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X CARCINOMA OF PROSTATE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>7 YRS</u>	
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>MAY 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>MAY 18 1966</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>William A. Pillsbury</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>5-24-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William A. Pillsbury</u>					22d. ADDRESS <u>Timonium, MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 26, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Cockeysville, Maryland</u>			
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>					25a. REC'D BY REGISTRAR <u>MAY 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>		

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VR A15 (4)  
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<div> <div>1</div> <div> <div>06438</div> <div>06436</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div>										
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTO. MEDICAL CENTER</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO., MARYLAND</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTO., MARYLAND</b> d. STREET ADDRESS <b>1417 STONEWOOD ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>DR. MILTON</b>			First <b>FREDERICK</b> Middle <b>ANDERSON</b> Last <b>ANDERSON</b>			4. DATE OF DEATH <b>MAY 1 1966</b>		Month <b>MAY</b> Day <b>1</b> Year <b>1966</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/13/99</b>		9. AGE (In years last birthday) <b>66</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DENTIST</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>TEETH</b>		11. BIRTHPLACE (County & State, or foreign country) <b>STANFORD, CONN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>FRANK Nells ANDERSON</b>					14. MOTHER'S MAIDEN NAME <b>Hilda Nelson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			16. SOCIAL SECURITY NO. <b>217-38-6190</b>		17. INFORMANT <b>PT'S HISTORY</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERITONITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>11221</b> (b) <b>PERFORATION OF OLD GASTROJEJUNOSTOMY 3 DAYS</b> (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>DISEASE</b>								INTERVAL BETWEEN ONSET AND DEATH <b>YES.</b>		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>March 4, 1966</u> to <u>May 1, 1966</u> , that (I) <u>we</u> last saw the deceased alive on <u>April 30, 1966</u> , and that death occurred at <u>A</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <b>Mercedes O. Alcantara</b>						22b. DATE SIGNED <b>May 1/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>MERCEDES O. ALCANTARA</b>						22d. ADDRESS <b>Greater Balt. Med. Center 6701 N</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>5/4/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City, town or county) <b>Balto. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Balto. 12, Md.</b>						25a. REC'D BY REGISTRAR <b>MAY 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>		

FRANK WELLS 4144 N. 1st St. Lincoln

~~\_\_\_\_\_~~ PNEUMONITIS

History of an ~~\_\_\_\_\_~~ 2 days  
HISTORIC CHRONIC  
DISEASE  
X

History of ~~\_\_\_\_\_~~ 4 days  
HISTORIC CHRONIC  
DISEASE  
X

MAY 1968



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

(M)

(I)

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06440 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06437

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Porto-Rural</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Houston</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5919 Meadow Rd Baltol</u>		d. STREET ADDRESS <u>Armour st</u>	
3. NAME OF DECEASED (Type or print) <u>Minnie Hammond</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 Mar 1875</u>
9. AGE (in years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mathias Hammond</u>		14. MOTHER'S MAIDEN NAME <u>Sally Parvis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Walter Stude, Baltimore, Md.</u>		Address <u>5919 Meadow Rd.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACVD</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>atherosclerotic Cardiovascular Disease</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John C. Hyle</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN C. HYLE</u>		22. DATE SIGNED <u>5-2-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 5, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Milford, Del.</u>	
24. FUNERAL DIRECTOR <u>William Berry Jr.</u>		ADDRESS <u>Milford, Del.</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 18 1966</u>			



1  
M  
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

RF

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Freeland</b> c. LENGTH OF STAY IN 1b <b>14 Yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Freeland Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Freeland</b> d. STREET ADDRESS <b>Freeland Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>FREDERICK DANIEL ATKINSON</b>					4. DATE OF DEATH Month <b>MAY</b> Day <b>5</b> Year <b>1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/12/1886</b>		9. AGE (In years last birthday) <b>79</b> yrs. IF UNDER 1 YEAR: Months <b>7</b> Days <b>15</b> IF UNDER 24 HRS.: Hours <b>15</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book Binder</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bookbinding</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Hiram Atkinson</b>					14. MOTHER'S MAIDEN NAME <b>Inez M. Heathcote</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Charles L. Atkinson</b> Address <b>4455 Old Frederick Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>G-I.S.C.V. disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH <b>24</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>A. M. France</b> EXAMINER'S NAME (Type) <b>A. M. FRANCE</b>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				
22. DATE SIGNED <b>5/5/66</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-9-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>G. Howard Strong 3207 W. North Ave.,</b>						25a. REC'D BY REGISTRAR DATE <b>MAY 6 1966</b>			
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FDR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/66

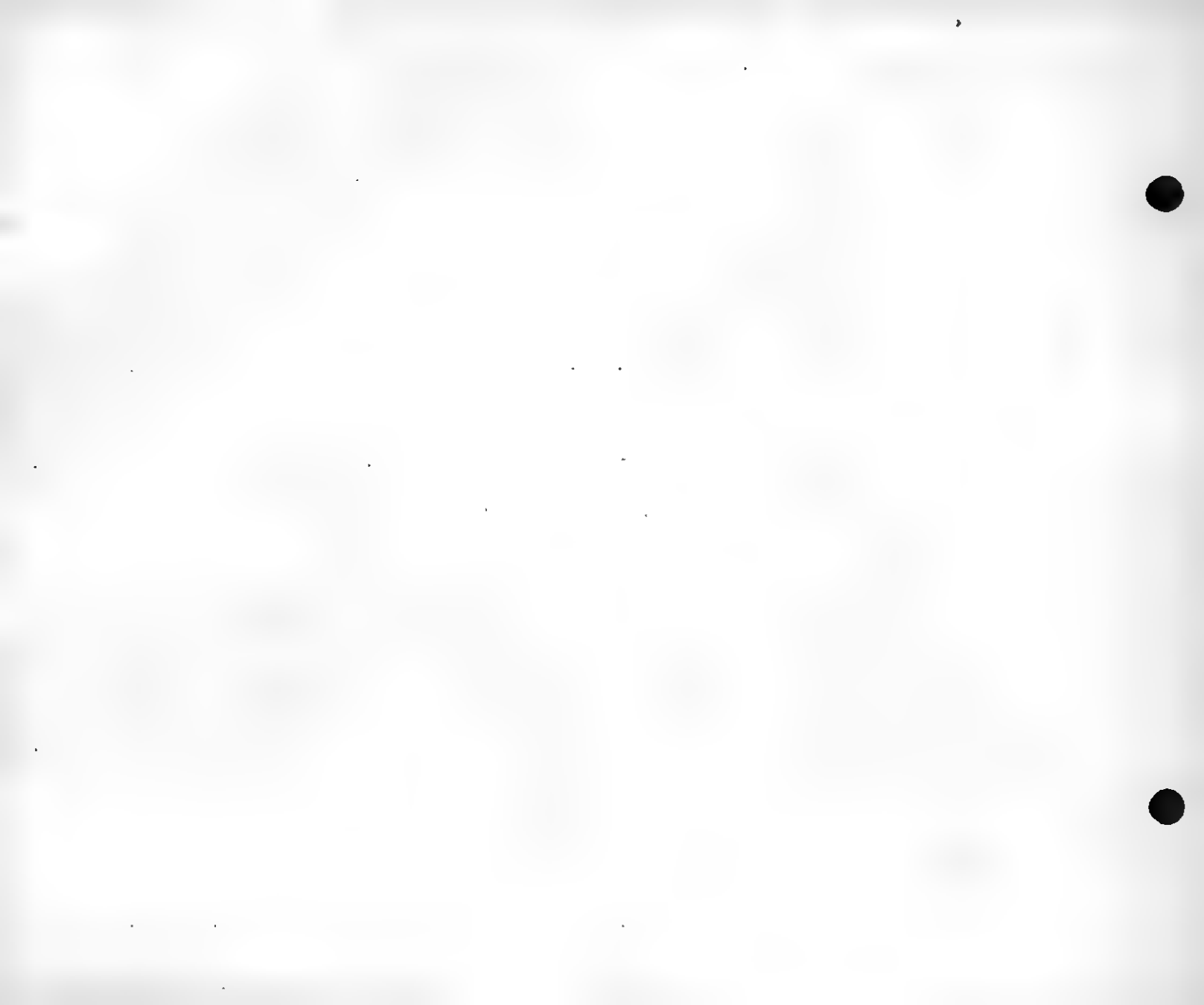
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06442

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06439

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b> c. LENGTH OF STAY in lb <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 205 - Sharon Road</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cockyesville</b> d. STREET ADDRESS <b>Box #205 - Sharon Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANK EDWARD BAKER</b>		4. DATE OF DEATH Month Day Year <b>5 15 1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>APRIL 25, 1909</b>
9 AGE (In years last birthday) <b>57 yrs</b>		10 IF UNDER 1 YEAR Months Days Hours Min	11 IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Co.</b>	
11 BIRTHPLACE (State or foreign country) <b>Cockeysville, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Baker</b>		14. MOTHER'S MAIDEN NAME <b>Ella Suard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>220-19-5100</b>	
17 INFORMANT <b>Margaret R. Kelbaugh, Cockeysville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>3rd degree burns over 80% of body with</b> <del>XXXXXX</del> Carbon monoxide poisoning DUE TO (b) <b>Carbon monoxide poisoning</b> (c) <b>Carbon monoxide poisoning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (a) <b>Carbon monoxide poisoning</b> (b) <b>Carbon monoxide poisoning</b> (c) <b>Carbon monoxide poisoning</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A Topsy PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Poured gasoline over himself - then set himself afire</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:45 AM 5 15 1966</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Cockeysville Balto. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b> EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>5-16-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-18-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph</b>	23d. LOCATION (City or Town) (County) (State) <b>Texas, Md. Balto.</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 23 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06443

06440

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baltimore County General Hosp.</b>		d. STREET ADDRESS <b>4304 Falls Road</b>	
3 NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>P.</b> Last <b>Baldwin</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/20/1900</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fire Department</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Baldwin</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Hooper</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>220-30-0247</b>	
17. INFORMANT <b>Mrs. Beatrice Baldwin</b>		Address <b>4304 Falls Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic Cancer, Kidney</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5-24</b> , 19 <b>66</b> , to <b>5-27</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>5-27</b> 19 <b>66</b> and that death occurred at <b>10:45</b> M, from causes on and on the date stated above			
22a. SIGNATURE <b>Dr. B. E. Caraway</b>		22b. DATE SIGNED <b>5-27-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. E. CARAWAY</b>		22d. ADDRESS <b>Baltimore County Gen. Hosp.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1 June 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Baltimore County, Maryland</b>
24. FUNERAL DIRECTOR <b>Burgee Funeral Home</b>		25a. REC'D BY REGISTRAR <b>May 31 1966</b>	
ADDRESS <b>3631 Falls Road</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

**C6444**

**C6444**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>1504 N. Pulaski Street</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Mack D. Barrington</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>5 1 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/17/96</b>
9. AGE (in years birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min <b>19 66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpentier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dennis Barrington</b>		14. MOTHER'S MAIDEN NAME <b>Hattie (MRS.) FLORENCE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO <b>578 18 20 90</b>	
17. INFORMANT <b>V.A. Hospital</b>		Address <b>Fort Howard, Maryland (Clinical Records)</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG, LEFT</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN DEATH AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>(M)</b> (this hospital) attended the deceased from <b>2/12/</b> 19 <b>66</b> to <b>5/1</b> 19 <b>66</b> , that <b>(M)</b> (we) last saw the deceased alive on <b>5/1</b> 19 <b>66</b> , and that death occurred at <b>7:45 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Raul F. de Castro</b>		22b. DATE SIGNED <b>5/2/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>RAUL F. DE CASTRO, M. D.</b>		22d. ADDRESS <b>VA HOSPITAL FORT HOWARD MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-5-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Elroy O. Wilson</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 3 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>2004 Orleans St. Baltimore, Maryland</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

AP 02 01 17

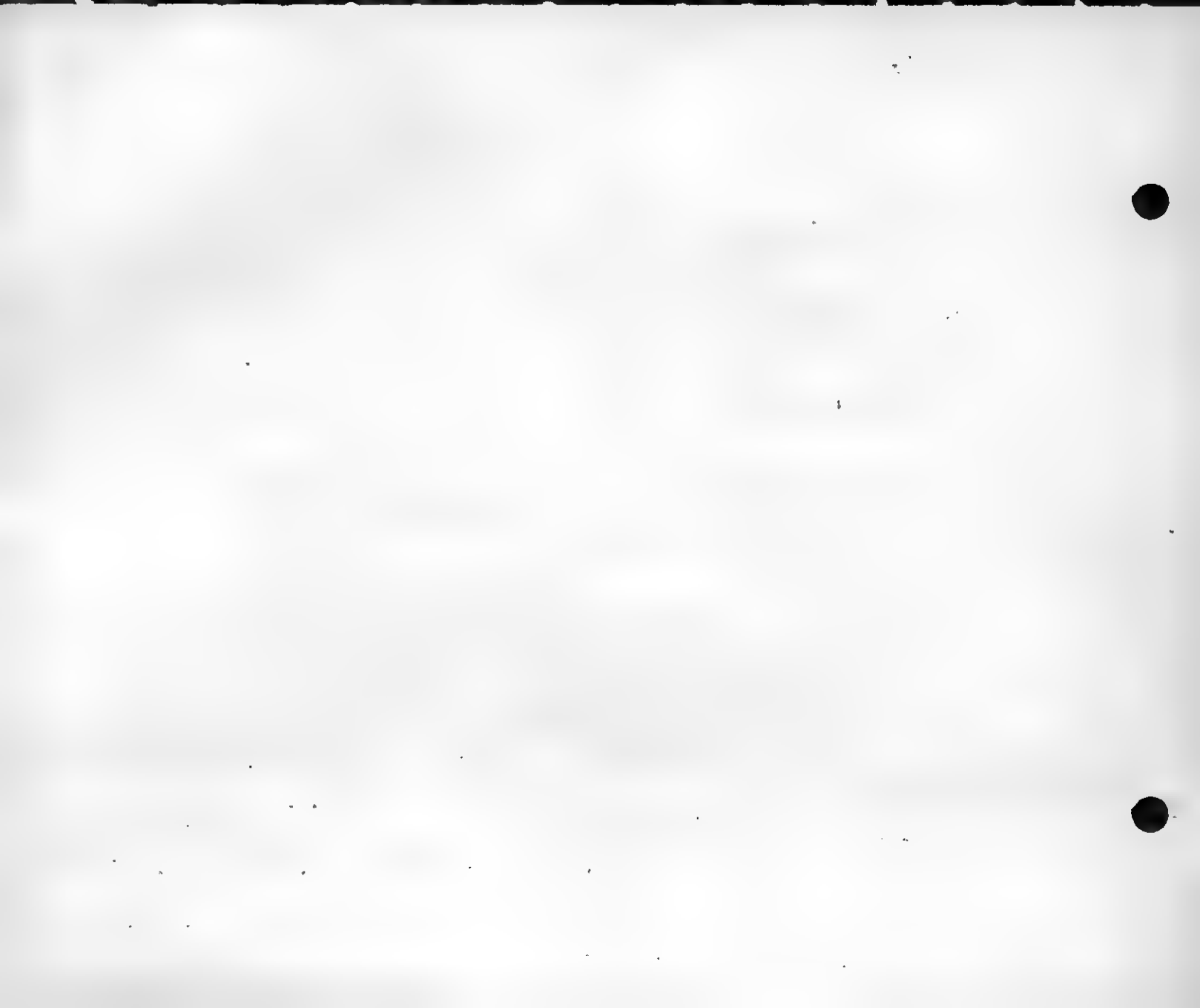
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Maryland</b> c. LENGTH OF STAY IN b					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3308 Rueckert Ave. #14</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Timothy Wayne Bauer</b>			4. DATE OF DEATH Month <b>May</b> , Day <b>8</b> , Year <b>1966</b>		9. AGE (In years last birthday) <b>30-4</b> IF UNDER 1 YEAR: Months <b>9</b> , Days <b>55</b> IF UNDER 24 HRS: Hours <b>55</b> , Min.				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 7, 1966</b>		10. AGE (In years last birthday) <b>30-4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Joseph Wayne Bauer</b>					14. MOTHER'S MAIDEN NAME <b>Mary Susan Meyers</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Father, above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyaline membrane disease</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 7, 1966</b> , to <b>May 8, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 8, 1966</b> , and that death occurred at <b>1:00</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>William J. Wilke MD</b>				22b. DATE SIGNED <b>May 8, 1966</b>					
22c. PHYSICIAN'S NAME (Type) <b>William Wilke, M.D.</b>				22d. ADDRESS <b>7620 York Road., Balto., Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/9/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
MAY 12 1966									





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>									
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <b>Baltimore</b> <b>MARYLAND</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> <b>Md.</b> <b>b. COUNTY</b>				
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>					<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) <b>Old Hanover Road</b>					<b>d. STREET ADDRESS</b> <b>2439 E. Preston Street</b>				
<b>3. NAME OF DECEASED</b> (Type or print) <b>Theodore</b>					<b>4. DATE OF DEATH</b> <b>May 29, 1966</b>				
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Colored</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Aug. 8, 1943</b>		<b>9. AGE</b> (In years last birthday) <b>22</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Warehouseman</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Theodore Baylor Sr.</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Reed</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)					<b>16. SOCIAL SECURITY NO.</b> <b>219-40-1071</b>		<b>17. INFORMANT</b> <b>Mrs. Bobbie Baylor</b> <b>2439 Preston St. Balto.</b>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a) Drowning (accidental)</b> <b>9298</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO</b> <b>(c)</b>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 hrs.</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <b>to save friend, who fell overboard from rowboat &amp; drowned.</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>Hour</b> <b>est. 5 p.m.</b> <b>May 29, 1966</b>				<b>20d. INJURY OCCURRED</b> <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Lake</b>		<b>20f. (City or town) (County) (State)</b> <b>Reisterstown Balto. Md.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> , <b>Accident</b> <input checked="" type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined manner</b> <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <b>D. D. Caples</b>					<b>22. DATE SIGNED</b> <b>5-31-66</b>				
<b>EXAMINER'S NAME (Type)</b> <b>D. D. Caples, M. D.</b>					<b>6 Hanover Rd. Reisterstown, Md.</b>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>6/2/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Calvary</b>			<b>23d. LOCATION</b> (City, town or county) (State) <b>Anne Arundel Co. Md.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Elliott Funeral Home 1129 Caroline Street Balto. Md.</b>					<b>25a. REC'D BY REGISTRAR</b> <b>JUN 20 1966</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>J. Charles Judge</b>				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN ID <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3442 Park Heights Ave., 21215</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>M.</b> Last <b>Berlin</b>		4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1891</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. FINDER 1 YEAR <input type="checkbox"/> FINDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FURNITURE MFG.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>KOPLAN BERLIN</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WORLD WAR I</b>		16. SOCIAL SECURITY NO. <b>MR. DAVID GOMBOROV, 730 EQUITABLE BLDG. #2</b>	
17. INFORMANT <b>MR. DAVID GOMBOROV, 730 EQUITABLE BLDG. #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary infarction</b> 465x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Marked hemoptysis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Old tuberculosis; Old hip fracture (4 years ago)</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 29, 1966</b> to <b>May 30, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 30, 1966</b> , and that death occurred at <b>12:41 PM</b> from the causes and on the date stated above.		22. SIGNATURE <b>William &amp; Willie</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> DATE SIGNED <b>May 30, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>William Wilkie, M.D.</b>		22d. ADDRESS <b>7620 York Road, 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 31, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MIKRO KODESH BETH ISRAEL</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN</b>		25a. REC'D BY REGISTRAR <b>MAY 31 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
2DM 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>06448</p> <p><b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b></p> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p>06444</p> </div> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b> (5618)					<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>5628 Utrecht Road #6</b>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Mary</b> Middle <b>Angela</b> Last <b>BLAKE</b>					<b>4. DATE OF DEATH</b> Month <b>MAY</b> Day <b>7</b> Year <b>1966</b>				
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>12/29/64</b>		<b>9. AGE</b> (In years last birthday) <b>1</b> yrs. <b>4</b> months <b>8</b> days <b>8</b> hours <b>1</b> min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore City</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Robert Bruce Blake</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>KOZLOWSKI, FRANCES</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Rosewood Records, Owings Mills, Md.</b> Address				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b> DUE TO (b) <b>Marked spasticity</b> DUE TO (c) <b>Severe retardation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 week since birth</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Microcephaly + Spasticity 2nd Maternal Rubella</b>									<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that (this hospital) attended the deceased from March 2, 1965, to May 7, 1966, that (we) last saw the deceased alive on May 7, 1966, and that death occurred at 8:30 AM, from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>Barbara W. Hedson</b>					<b>22b. DATE SIGNED</b> <b>May 7, 1966</b>		<b>22c. PHYSICIAN'S NAME (Type)</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>					<b>23b. DATE THEREOF</b> <b>5-10-66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National Cem</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>BALTO., MD.</b>
<b>24. FUNERAL DIRECTOR</b> <b>Charles S. Zeiler</b>					<b>25a. REC'D BY REGISTRAR</b> <b>MAY 12 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO</b> d. STREET ADDRESS <b>6065 Harford Rd</b> <b>601 N. CHARLES ST</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>HARVEY</b> Last <b>BLESSING</b>		4. DATE OF DEATH Month <b>5</b> Day <b>9</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/18/82</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>8</b> Days <b>3</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTO.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Simon Blessing</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Frostberg</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>John</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>165X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>METASTATIC CARCINOMA OF LEFT LUNG AND CHRONIC ACTIVE PULMONARY TUBERCULOSIS, BILATERAL</b> DUE TO (c) <b>ARTERIOCLEROTIC CARDIOVASCULAR DISEASE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOCLEROTIC CARDIOVASCULAR DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>May 9, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 3, 1966</b> and that death occurred at <b>8:50 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edmund P. Lively</b>		22b. DATE SIGNED <b>5-9-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edmund P. Lively</b>		22d. ADDRESS <b>6701 N. Charles Street</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>3/11/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oakwood</b>	23d. LOCATION (City, town or county) (State) <b>BALTO Co.</b>
24. FUNERAL DIRECTOR <b>Ed Heumann</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> 25c. DATE <b>MAY 16 1966</b>	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06446

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Try Hall Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford Co</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> d. STREET ADDRESS <u>19 Harrison Ave. Balt-21220</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs Emma M. Bloom</u> First Middle Last 4. DATE OF DEATH <u>May 23 1966</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept 2 1870</u> 9. AGE (In years last birthday) <u>95</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Dillinger</u> 14. MOTHER'S MAIDEN NAME <u>Brinkman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>Mrs Bertha M. Hayes -Owings Mills, Md.</u> 17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 301A DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebrovascular arteriosclerosis</u> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a); 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>4 days 25 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1958</u> to <u>May 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 23, 1966</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Louis Semenovoff</u> M.D. 22b. ADDRESS <u>2108 CREMS RD, BALTO, MD 21220</u> 22c. PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF</u> 22d. DATE SIGNED <u>5/23/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>5-26-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Mem. Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Abingdon, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc Baltimore, Md.</u> ADDRESS 25. REC'D BY REGISTRAR <u>MAY 25 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06451

06447

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>1 mo. 13 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21218</b> d. STREET ADDRESS <b>1519 Greendale Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Stella</b> Last <b>Blusiewicz</b>		<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>26</b> Year <b>1966</b>		<b>5. SEX</b> <b>Female</b>									
<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9-15-93</b>									
<b>9. AGE</b> (In years last birthday) <b>72</b> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own home</b>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months	Days												
	Hours												
	Min.												
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Lithuania-Poland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Michael Zajkowski</b>									
<b>14. MOTHER'S MAIDEN NAME</b> <b>Dorothy ???</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>-</b>		<b>16. SOCIAL SECURITY NO.</b> <b>215-09-1225</b>									
<b>17. INFORMANT</b> <b>Mr. Joseph S. Blusiewicz</b>		<b>Address</b> <b>1519 Greendale</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>Generalized carcinomatosis</b>									
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <b>1962</b>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>DR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</td> <td>DUE TO</td> </tr> <tr> <td></td> <td>(b)</td> </tr> <tr> <td></td> <td>DUE TO</td> </tr> <tr> <td></td> <td>(c)</td> </tr> </table>		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO		(b)		DUE TO		(c)	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO												
	(b)												
	DUE TO												
	(c)												
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)									
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from April 14, 1966 to May 26, 1966, that (I) (we) last saw the deceased alive on May 26, 1966, and that death occurred at 2:35 PM, from the causes and on the date stated above.</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>22a. SIGNATURE</b> <b>Hector C. Mendez</b>		<b>22b. DATE SIGNED</b> <b>May 26, 1966</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Hector C. Mendez</b>									
<b>22d. ADDRESS</b> <b>7620 York Road</b>		<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>									
<b>23b. DATE THEREOF</b> <b>5/30/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Rosary</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b>									
<b>24. FUNERAL DIRECTOR</b> <b>J. F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAY 31 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>									

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
06452		06448												
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>Baltimore</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21204</b> d. STREET ADDRESS <b>408 Stevenson Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>William</b> First <b>B.</b> Middle <b>Boguess</b> Last			4. DATE OF DEATH <b>May</b> Month <b>13</b> Day <b>1966</b> Year			5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <b>July 18, 1876</b>			9. AGE (In years last birthday) <b>89</b> yrs.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>William Boguess</b>			14. MOTHER'S MAIDEN NAME <b>Marceline Wright</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>Miss Revela Bozman</b>		
17. INFORMANT <b>City #4</b>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Acute and chronic bronchitis with bronchopneumonia</b> DUE TO (c) <b>monia</b>			INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <b>May 10, 1966</b> to <b>May 13, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 13, 1966</b> , and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above.			22a. SIGNATURE <b>D.R. Govinda Rao</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>May 14, 1966</b>			22c. PHYSICIAN'S NAME (Type) <b>D.R. Govinda Rao, M.D.</b>		
22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>5/16/66</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore County, Md.</b>		
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>6500 York Rd.</b>			25a. REC'D BY REGISTRAR <b>MAY 17 1966</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			25c. DATE <b>MAY 17 1966</b>			25d. BALTO. 12, Md.		





## CERTIFICATE OF DEATH

06453

06449

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN TB <b>127 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>--</b> Last <b>BOLLINGER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>26</b> Year <b>19 66</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 22, 1889</b>
9 AGE (In years last birthday) yrs <b>76</b>		10 IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	
11 BIRTHPLACE (County & State or foreign country) <b>WESTMINSTER, MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>ABDIAH BOLLINGER</b>		14. MOTHER'S M.A.DEN NAME <b>MARTHA UNDERZEACK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16 SOCIAL SECURITY NO <b>217 36 32 01</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>FRONTAL LOBE INFARCTION, POST OPERATIVE</b> DUE TO (b) <b>EXCISION OF MENINGIOMA</b> DUE TO (c) <b>EXCISION OF MENINGIOMA</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <b>5/19/66</b> , 19 to <b>5/26/66</b> , 19, that (b) (we) last saw the deceased alive on <b>5/26/66</b> , 19, and that death occurred at <b>7:25 AM</b> , from causes on and on the date stated above			
22a SIGNATURE <i>[Signature]</i>		22b DATE SIGNED <b>May 26, 1966</b>	
22c PHYSICIAN'S NAME (Type) <b>ROBERT G. HENNESSY, M. D.</b>		22d ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>5/29/66</b>	23c NAME OF CEMETERY OR CREMATORY <b>DEER PARK CHURCH CEMETERY WESTMINSTER, MD.</b>	23d. LOCATION (City or Town) (County) (State) <b>ROTH</b>
24. FUNERAL DIRECTOR <i>[Signature]</i> <b>Myers Funeral Home</b> <b>Westminster, Maryland</b>		25a REC'D BY REGISTRAR <b>MAY 31 1966</b>	
25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



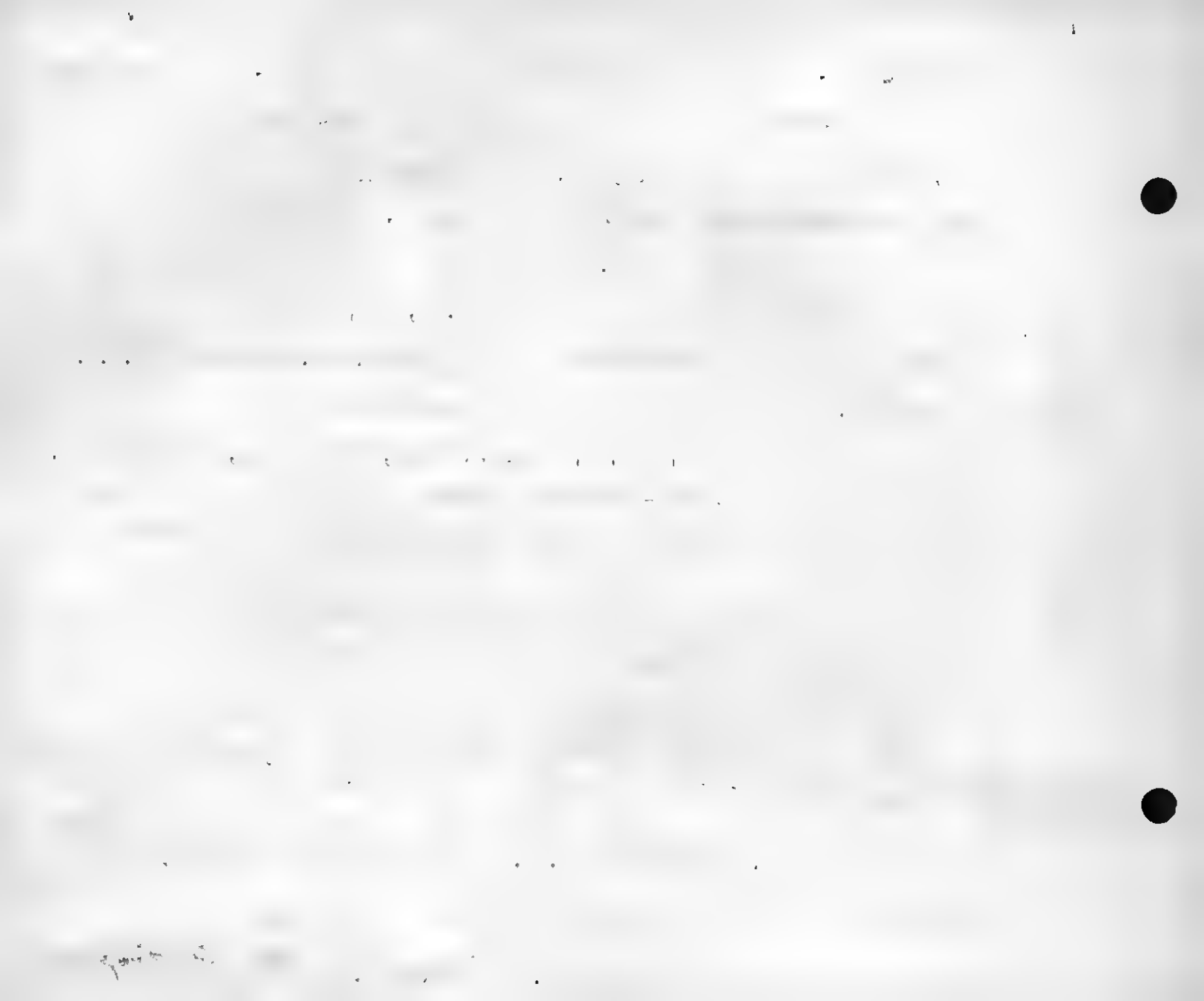
## CERTIFICATE OF DEATH

06450

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>285 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>2911 W. NORTH AVENUE</b>	
3 NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>T.</b> Last <b>BOND</b>		4 DATE OF DEATH Month <b>MAY</b> Day <b>20</b> Year <b>1966</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>MARCH 4, 1897</b>
9 AGE (In years last birthday) yrs. <b>69</b>		10 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>MONTGOMERY CO. MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>CHARLES J. BOND</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE HALL</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO <b>217 05 77 78</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b> 148X DUE TO <b>CARCINOMA OF LEFT TONSILLAR REGION WITH METASTASES</b> (b) <b>2 1/2 YEARS</b> DUE TO (c)		INTERVAL BETWEEN DEATH AND DEATH <b>RECENT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/9/65</b> , 19__ to <b>5/20/66</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>5/20/66</b> , 19__, and that death occurred at <b>5:00AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <i>George C. McElpatrick</i>		22b. DATE SIGNED <b>5/20/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE C. MC ELPATRICK, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>May 24, 1966</b>	
23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24 FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b>		25a REC'D BY REGISTRAR <b>DATE MAY 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>John Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Createe Baltimore Med Center</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore 12,</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>601 Benning house Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARY F. Bosley</u> First Middle Last <b>4. DATE OF DEATH</b> <u>5</u> <u>24</u> <u>1966</u> Month Day Year						<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>Ca u</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>8-16-08</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>57</u> yrs. <b>9. AGE</b> (In years last birthday) <u>57</u> <b>10. IF UNDER 1 YEAR</b> Months <u>5</u> Days <u>24</u> Hours <u>19</u> Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Unknown SALES LADY</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>HAMBERGER</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>						<b>13. FATHER'S NAME</b> <u>DAVID B. BOSLEY</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>MARTHA E. POOLE</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Unknown NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>216-07-9036</u> <b>17. INFORMANT</b> <u>MRS. MARGARET E. WHEDBEE</u> Address						<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular respiratory collapse</u> (b) <u>Cancer of the breast</u> (c) <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>						<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>10</u> p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>MAY 3</u> , 19 <u>66</u> , <b>to</b> <u>MAY 24</u> , 19 <u>66</u> <b>that (I) (we) last saw the deceased alive on</b> <u>MAY 24</u> , 19 <u>66</u> , <b>and that death occurred at</b> <u>1:07 PM</u> , <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>E. Lively</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>E. Lively</u>						<b>22b. DATE SIGNED</b> <u>5-24-66</u> <b>22d. ADDRESS</b> <u>GR. BALTO MED. CENTER, TOWSON, MD.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>5/27/1966</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Stablersville</u> <b>23d. LOCATION (City, town or county) (State)</b> <u>Parkton Md.</u>				<b>24. FUNERAL DIRECTOR</b> <u>Henry W. Jenkins &amp; Sons Co. 4905 York Road Baltimore 12, Md.</u> <b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>25b. REGISTRAR'S SIGNATURE</b>							



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06456

06452

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>18 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>8045 Gough Street</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Lester L. Bowings</b>				<b>4. DATE OF DEATH</b> Month <b>5</b> Day <b>8</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2/16/07</b>	9. AGE (In years lost birthday) yrs <b>59</b>	IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tug Boats</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Johnsville, Maryland</b>			
13. FATHER'S NAME <b>Samuel L. Bowings</b>				14. MOTHER'S MAIDEN NAME <b>Clara Warner</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>217 01 73 66</b>		17. INFORMANT <b>V.A. Hospital</b> Address <b>Fort Howard, Maryland (Clinical Records)</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INFARCTION MYOCARDIUM</b> 4201 DUE TO (b) <b>ARTERIOSCLEROTIC CORONARY THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>18 DAYS</b> <b>YEARS</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>21. I certify that (X) (this hospital) attended the deceased from 4/20, 19 66, to 5/8, 19 66 that (X) (we) last saw the deceased alive on 5/8, 19 66, and that death occurred at 9:50 a.m. causes and on the date stated above.</b>							
22a. SIGNATURE <b>John D. Talbert</b>				22b. DATE SIGNED <b>5/9/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL CREMATION, REMOVA (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/12/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDEN PARK NATIONAL</b>			
23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>		24. FUNERAL DIRECTOR <b>Joseph D. Zannino Jr.</b>					
25a. ADDRESS <b>ZANNINO FUNERAL HOME</b>		25b. REC'D BY REGISTRAR <b>MAY 11 1966</b>		25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
25d. DATE <b>257 S. Conkling St. Baltimore, Md.</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ridgeway Manor 5743 Edmondson Ave.</u>		d. STREET ADDRESS <u>884 Benninghaus Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>L.</u> Last <u>Boyd</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1874</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New Oxford, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Maus</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Hicks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Helen Smallwood</u>		Address <u>884 Benninghaus Rd. (12)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>66</u> to <u>May 7</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>May 1</u> , 19 <u>66</u> , and that death occurred at <u>PM</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Willie Goodman</u>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>Willie Goodman MD</u>		22d. ADDRESS <u>133-1 Sulphur Spring Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 11, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks, Inc.</u>		25a. REC'D BY REGISTRAR <u>May 11 1966</u>	
ADDRESS <u>1217 St. Paul St.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item #230 & 231 Film 133 5/21/66 pc

06458

# CERTIFICATE OF DEATH

06454

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Baltimore</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				c. LENGTH OF STAY IN <b>32 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1103 North Bond</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM JONES BOYD</b>				4. DATE OF DEATH Month <b>5</b> Day <b>21</b> Year <b>1966</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/24/1903</b>	9. AGE (In years last birthday) yrs. <b>62</b>	IF UNDER 1 YEAR Months <b>21</b> Days <b>21</b> Hours <b>19</b> Min <b>66</b>		IF UNDER 24 HRS. Hours <b>19</b> Min <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MARION JONES</b>				14. MOTHER'S MAIDEN NAME <b>DAISY HAMMOND</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>unknown</b>		17. INFORMANT <b>SPRING GROVE HOSP. RECORD</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC FAILURE</b> 2865 DUE TO <b>Malnutrition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO <b>dehydration</b> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>Feb. 1</b> , 19 <b>66</b> to <b>May 21</b> , 19 <b>66</b> that (we) last saw the deceased alive on <b>May 21</b> , 19 <b>66</b> , and that death occurred at <b>2:00</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Isare Kopits</b>				22b. DATE SIGNED <b>5-21-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Isare Kopits M.D.</b>	
22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>				22e. REC'D BY REGISTRAR <b>Charles J. Jager</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Anatomy Board of Md.</b>		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR <b>Newell Funeral Home Fikesville, Md.</b>				25. REGISTRAR'S SIGNATURE <b>Charles J. Jager</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

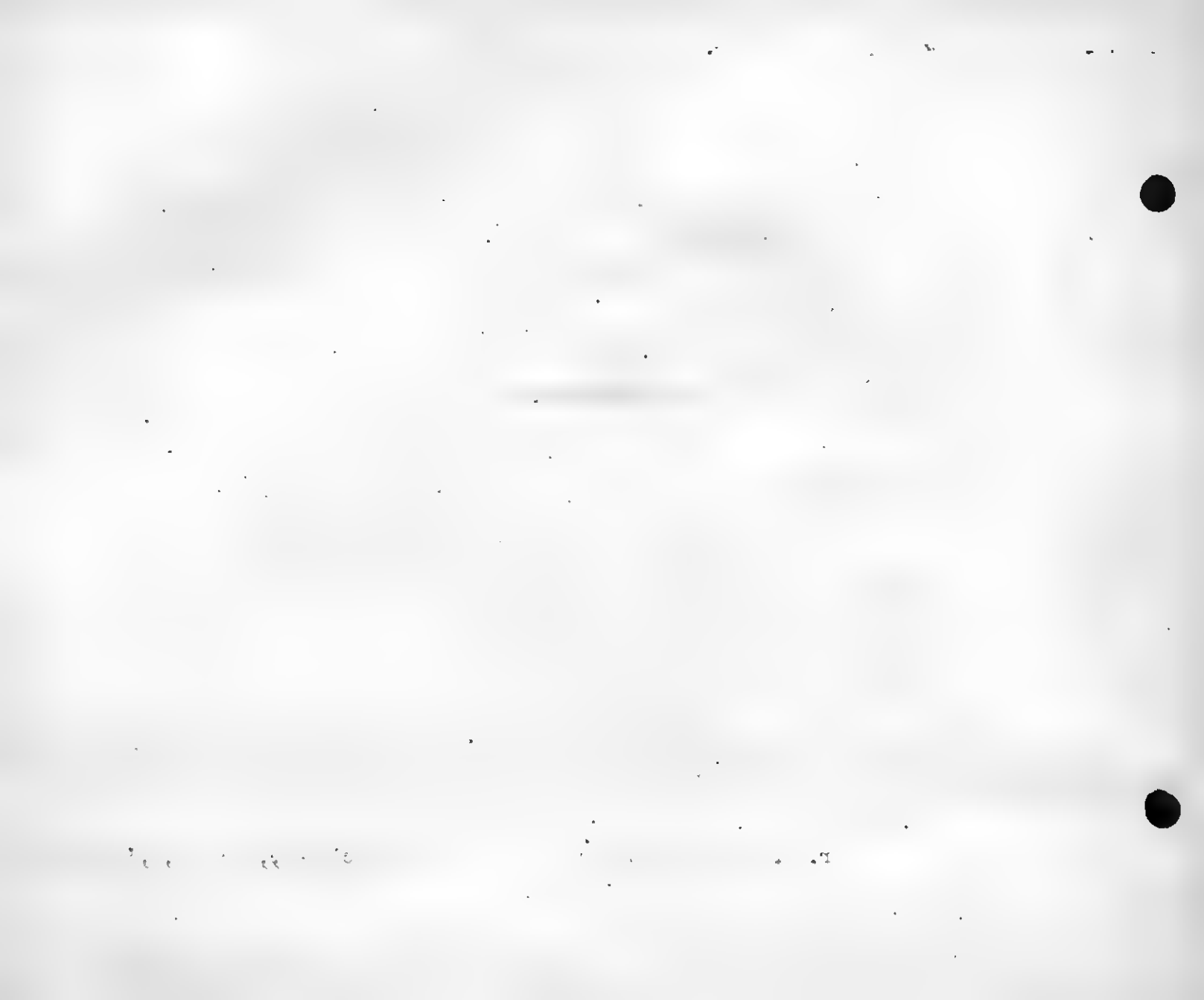
## CERTIFICATE OF DEATH

06459

06455

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN TB <u>3 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>203 N. Rolling Road</u>				d. STREET ADDRESS <u>203 N. Rolling Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mabel L. Brandon</u>				4. DATE OF DEATH Month Day Year <u>May 25 1966</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> <u>NAMES MARRIED</u> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>June 3, 1919</u>	
9. AGE (in years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Isle of Pines, Cuba</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Josiah B. Brandon</u>				14. MOTHER'S MAIDEN NAME <u>Effie J. Lottin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>051-16-6796</u>		17. INFORMANT <u>Alfred N. Brandon</u> Address <u>203 North Rolling Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Brain</u> DUE TO (b) <u>Adenocarcinoma Ovary</u> DUE TO (c) <u>6 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1, 1965</u> to <u>May 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 21 1966</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A. Bradley Daugharthy</u> M.O.						22b. DATE SIGNED <u>5-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. A. Bradley Daugharthy</u>				22d. ADDRESS <u>1264 Francis Ave., Arbutus Md 21227</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Springfield, 8728 Liberty Road</u>				25a. REC'D BY REGISTRAR <u>MAY 31 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BP

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN ID Two years		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		d. STREET ADDRESS 1621 Landon Road		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Kenneth Brodie		First		Middle		Last		4. DATE OF DEATH May 21,		Month		Day		Year 19 66	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 10, 1913		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office				11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles A. Brodie								14. MOTHER'S MAIDEN NAME Lillian I. Stuart							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-05-4139				17. INFORMANT Pauline F. Brodie (Wife)				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden at least 1 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Charles F. O'Donnell				Address (Street, city, town, or county)				22. DATE SIGNED 5/21/66							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 24, 1966				23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery				23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Eugenia K. Seitz				ADDRESS 5209 York Road Baltimore, Md. 21212				25a. REC'D BY REGISTRAR MAY 24 1966				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 3, 17 Film 3378 6/25/66 mh

06461

CERTIFICATE OF DEATH

06457

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HANDALISTOWN, MD. 21133</b>				c. LENGTH OF STAY IN 1b <b>Baltimore, Maryland 21208</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BALTIMORE COUNTY GENERAL HOSPITAL, INC.</b>				d. STREET ADDRESS <b>4106 Milford Mill Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Herbert <del>Thomas</del> Brown Sr.</b>				4 DATE OF DEATH <b>May 26 19 66</b>			
5 SEX <b>MALE</b>		6 COLOR OR RACE <b>WHITE</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>Sept 8, 1895</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Roofing</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas Brown</b>				14. MOTHER'S MAIDEN NAME <b>Isabella Ruff</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO <b>216-09-1175</b>		17. INFORMANT <b>Mrs. Florence Brown</b> Address <b>4106 Milford Mill Rd. 3504/Jean Drive Balto 7</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Massive Aspiration of stomach content</b> <b>441X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchopneumonia, confluent of all lobes</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/20</b> , 19 <b>66</b> , to <b>5-26</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>5-26</b> 19 <b>66</b> and that death occurred at <b>1:10p</b> M, from causes on and on the date stated above							
22a. SIGNATURE <b>L. B. Lerma</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/26/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. B. Lerma</b>				22d. ADDRESS <b>Balto Co. Gen. Hosp</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-28-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Living Bays 8728 Liberty Rd. Handallstown, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 31 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## CERTIFICATE OF DEATH

06458

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> c. LENGTH OF STAY IN 1b <b>MD.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>FOREST HAVEN NURSING HOME.</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3132 CHESTER AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>BIRDIE M. DALL</b>			4. DATE OF DEATH <b>5/14/66</b> 19 <b>66</b>		
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10/23/70</b>		9. AGE (In years last birthday) <b>95</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MRS PAUL M. RYLANDER PELHAM MANOR, N.Y.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART - SCIENTIFIC CAUSE - VASCULAR</b> <b>201</b> DUE TO <b>USELESS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>IN 40 CHRONIC INFLAMMATION</b> DUE TO (c) <b>PULMONARY EMBOLISM</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/1</b> , 19 <b>66</b> , to <b>5/14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/14</b> , 19 <b>66</b> , and that death occurred at <b>8:00 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>John H. Shanahan</b>			22b. DATE SIGNED <b>5/16/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>John H. Shanahan M.D.</b>			22d. ADDRESS <b>5808 ELMORRISON AVE BALTO. MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/16/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>	
23d. LOCATION (City, town or county) <b>BALTO. MD.</b>		(State)			
24. FUNERAL DIRECTOR <b>Paul E. Chaney</b>			25a. REC'D BY REGISTRAR <b>MAY 17 1966</b>		
ADDRESS			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
06463					CERTIFICATE OF DEATH					06459				
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21212</b> d. STREET ADDRESS <b>1309 Walker Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <b>Christopher J. Buscemi</b>					4. DATE OF DEATH Month Day Year <b>May 3, 1966</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-22-60</b>		9. AGE (In years last birthday) <b>5</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Peter C. Buscemi</b>					14. MOTHER'S MAIDEN NAME <b>Lorraine E. Lang</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Peter C. Buscemi</b>				Address <b>(Same)</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningococcemia and meningococcal meningitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>May 2, 1966</b> , to <b>May 3, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 3, 1966</b> , and that death occurred at <b>9:45M</b> , from the causes and on the date stated above.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
22a. SIGNATURE <b>R. PeBenito, M.D.</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>May 3, 1966</b>							
22c. PHYSICIAN'S NAME (Type) <b>R. PeBenito, M.D.</b>					22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/7/66.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>							
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>					ADDRESS <b>21214</b>		25a. REC'D BY REGISTRAR <b>MAY 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>g Charles Judge</b>					



## CERTIFICATE OF DEATH

CE460

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>139 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>725 GEORGE STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>--</b> Last <b>BUTLER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>12</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 4, 1891</b>
9. AGE (In years last birthday) yrs <b>74</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>15</b> Hours <b>15</b> Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>CLAY COUNTY, GEORGIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY BUTLER</b>		14. MOTHER'S MAIDEN NAME <b>CLARA HAWK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-1</b>		16. SOCIAL SECURITY NO. <b>217 07 1667</b>	
17. INFORMANT <b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>203x</b> IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLI, PNEUMONIA AND SEPTICEMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>MULTIPLE MYELOMA</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 24</b> , 19 <b>65</b> , to <b>May 12</b> , 19 <b>66</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 12</b> , 19 <b>66</b> , and that death occurred at <b>5</b> p.m. from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence F. Awalt, Jr.</i> M.D.		22b. DATE SIGNED <b>5 13 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE F. AWALT, JR., MD.</b>		22d. ADDRESS <b>VET. ADM. HOSP., FT. HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-16-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <i>Charles R. Law</i>		25a. REC'D BY REGISTRAR <b>CHARLES R. LAW FUNERAL DIRECTOR</b> <b>002 MADISON AVE. BALTIMORE, MD.</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE <b>MAY 18 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06465

06461

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE Md.		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN ID 9 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chapel Hill Conv. Home		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle M. Last CABLE		4. DATE OF DEATH Month 5 Day 25 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1879	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Duties		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Smithsburg Md.	
13. FATHER'S NAME John W. Cable		14. MOTHER'S MAIDEN NAME May Martin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT John Cable 3rd. Sykesville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral aneurysm on occasion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Cardio-failure, arteriosclerosis</i> DUE TO (c) <i>generalized severe - Chronic Brain Syndrome</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH 1915 + 5-25-66
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 1965 to 5-25-66, that (I) (we) last saw the deceased alive on 5-25-1966, and that death occurred at 8:30 PM, from the causes and on the date stated above.					
22a. SIGNATURE <i>Howard L. Hall</i>		22b. DATE SIGNED 5-25-66		22c. PHYSICIAN'S NAME (Type) Howard L. Hall	
22d. ADDRESS Sykesville, Md.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/28/66		23c. NAME OF CEMETERY OR CREMATORY Green Hill	
23d. LOCATION (City, town or county) Waynesboro Franklin Co., Pa.		23e. REC'D BY REGISTRAR MAY 27 1966			
23f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>8 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>413 Oella Avenue</b>		d. STREET ADDRESS <b>413 Oella Avenue</b>	
3 NAME OF DECEASED (Type or print) <b>John Sherman Campbell</b>		4 DATE OF DEATH <b>May 8, 1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>9/26.1927</b>
9 AGE (n years last birthday) <b>38 yrs</b>		10 IF UNDER 1 YEAR Months <b>1</b> Days <b>8</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pressman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paper Mill</b>	
11 BIRTHPLACE (State or foreign country) <b>Carey Kentucky</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>William Campbell</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Holt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>219-22-8407</b>	
17 INFORMANT <b>Mrs. Pauline Triplett</b>		Address <b>413 Oella Avenue</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>3221</b> IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Chronic alcoholism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) <b>ost</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>GEO. S. M. KIEFFER</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>GEO. S. M. KIEFFER MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-11-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Frederick Ave. Baltimore, Md</b>	
24 FUNERAL DIRECTOR <b>Easton Funeral Home</b>		ADDRESS <b>Catonsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>MAY 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>21218</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson, 21204</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dulaney Towson Nursing Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel H Carroll</u>				4. DATE OF DEATH Month Day Year <u>May 6 1966</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 23, 1878</u>		9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Harford County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Patrick Carroll</u>						14. MOTHER'S MAIDEN NAME <u>Anne Bannon</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>219 30 4403</u>		17. INFORMANT <u>Dulaney Towson Nursing Home, 111 West Rd.</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>May 1</u> , 19 <u>66</u> , to <u>May 6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 6</u> , 19 <u>66</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.													
22a. SIGNATURE <u>Laurence C. Post</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/7/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C. Post</u>						22d. ADDRESS <u>6805 York Rd. - Baltimore 21212 MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/9/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air Maryland</u>					
24. FUNERAL DIRECTOR <u>John A. Moran, Inc. 3000 E. Balto. St. Balto.</u>						25a. REC'D BY REGISTRAR <u>MAY 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>06468</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div> <div>06464</div> </div> </div>																	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6 Dungarrie Rd.</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>6 Dungarrie Rd.</u>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Annie</u> Middle <u>Barford</u> Last <u>Cashman</u>						<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>16</u> Year <u>1966</u>											
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb. 13, 1901</u>		<b>9. AGE</b> (In years last birthday) <u>65</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Penn.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>									
<b>13. FATHER'S NAME</b> <u>James F. Annan</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ruffenbart</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> (If yes give war or dates of service) <u>----</u>		<b>17. INFORMANT</b> Address <u>Henry S. Cashman 6 Dungarrie Rd</u>											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4321</u> DUE TO <u>Anoxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> (c) <u>Cerebrovascular Cardiovascular Disease</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 yrs.</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>7-1</u> , 19 <u>60</u> , to <u>5-16</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>5-16</u> , 19 <u>66</u> , and that death occurred at <u>1<sup>15</sup></u> AM; from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <u>Robert C. Irwin</u>						<b>22b. DATE SIGNED</b> <u>5-16-66</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Robert C. Irwin</u>		<b>22d. ADDRESS</b> <u>5550 Balto. Nat'l Pike Balto. Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>5-18-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lincoln Park Cem.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Balto. Md.</u>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Volley - Cronough J.A. Catonsville, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAY 18 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>2yr11mth28dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkton, Maryland</b> d. STREET ADDRESS <b>112 Maffitt Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Clara A. Cassidy</b>			4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>19 66</b>								
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 3, 1883</b>		9. AGE (in years last birthday) <b>82</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>nurse</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>James McGaw</b>					14. MOTHER'S MAIDEN NAME <b>Rachel Howard</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>			16. SOCIAL SECURITY NO. <b>020-24-9577</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>4500</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Decubitus ulcerations</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (if this hospital) attended the deceased from <b>March 18, 19 63</b> to <b>May 3, 19 66</b> , that (we) last saw the deceased alive on <b>May 3, 19 66</b> , and that death occurred at <b>8:00</b> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <b>Stella Wachslar</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5-4-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>					22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/5/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL</b>		23d. LOCATION (City, town or county) (State) <b>BALTO. MD.</b>					
24. FUNERAL DIRECTOR <b>E. J. MacNabb</b>					ADDRESS <b>301 Frederick Ave</b>		25a. REC'D BY REGISTRAR <b>MAY 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <b>116 Glenwood Ave.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>116 Glenwood Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Pauline</b> Middle <b>Anna</b> Last <b>Cerniglia</b>				4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>1966</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 22, 1906</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Schirmer</b>				14. MOTHER'S MAIDEN NAME <b>Ann -----</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT <b>Nicola Cerniglia-116 Glenwood Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac failure</b> 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular disease and Emphysema</b> (c) <b>Diabetes Mellitis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Geo. S. M. Kefler</b> M.D.				22. DATE SIGNED <b>May 23-66</b>			
EXAMINER'S NAME (Type) <b>Geo. S. M. Kefler M.D.</b>				Address (Street, city, town, or county) <b>1010 Leeds Ave #9</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-27-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Farley - Corrough General Home - Catonsville, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 31 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06472					06467				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood 21204</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1807 Roland Avenue</u>					d. STREET ADDRESS <u>1807 Roland Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>Luther</u> Last <u>Chenoweth</u>					4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 18, 1890</u>		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman-retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co. Police</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>William Chenoweth</u>					14. MOTHER'S MAIDEN NAME <u>Annie C. De</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Family records</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cerebral</u> <u>741X</u> DUE TO (b) <u>Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Asthma</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10/21, 1949</u> to <u>5/22, 1966</u> , that (I) (we) last saw the deceased alive on <u>3/3, 1966</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Charles Chenoweth</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<u>Burial</u>		<u>May 26, 1966</u>		<u>Baltimore Memorial Park</u>		<u>Parkville, Md.</u>			
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>					25a. REC'D BY REGISTRAR <u>MAY 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



FOR STATE  
HEALTH DEPT.

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VR A15ME (5)  
GM 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c LENGTH OF STAY IN b <b>12 YEARS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>LUTHERVILLE</b>		d. STREET ADDRESS <b>504 College Ave.</b>	
3 NAME OF DECEASED (Type or print) First <b>IRA</b> Middle <b>FRANCIS</b> Last <b>CHESTER</b>		4 DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 2, 1909</b>
9 AGE (In years last birthday) yrs <b>57</b>		10 IF UNDER 1 YEAR Months <b>12</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postal Worker</b>		10b KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>	
11 BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ira B. Chester</b>		14. MOTHER'S MAIDEN NAME <b>Mary F. Andrews</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W. II</b>		16 SOCIAL SECURITY NO <b>218-18-9387</b>	
17 INFORMANT <b>MRS. ANNETTA CHESTER</b>		Address <b>SAME AS 2D</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4/20/1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		22. DATE SIGNED <b>5/16/66</b>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>5-20-66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	23d LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson Inc.</b>		ADDRESS <b>1050 York Rd.</b>	
25a REC'D BY REGISTRAR <b>MAY 23 1966</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please receive carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					c. LENGTH OF STAY IN 1b <b>21214</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Baby Girl</b> Middle <b>CHILDRESS</b> Last					4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1966</b>				
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 15 1966</b>		9. AGE (In years last birthday) <b>14</b> IF UNDER 1 YEAR: Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James M. Childress</b>					14. MOTHER'S MAIDEN NAME <b>Phyllis G. Jentry</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>James M. Childress</b>			Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anencephaly.</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 15</b> , 19 <b>66</b> , to <b>May 16</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 16</b> , 19 <b>66</b> , and that death occurred at <b>12</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Glocrito G. Sagisi</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>May 16, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Glocrito G. Sagisi, M.D.</b>						22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5-16-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>						ADDRESS <b>Baltimore, Md.</b>		25. REC'D BY REGISTRAR <b>MAY 17 1966</b>	
						REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06474

06470

1 PLACE OF DEATH a COUNTY <u>Balto</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Balto</u>	
b CITY OR TOWN (If out of corporate limits write RURAL and give nearest town) <u>Mt. Wilson</u>		c LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mt. Wilson State Hosp.</u>		d STREET ADDRESS <u>Mt. Wilson State Hosp.</u>	
3 NAME OF DECEASED (Type or print) <u>KATHERINE ELEANOR CLARENDON</u>		4 DATE OF DEATH <u>MAY 13 1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-7-10</u>
9 AGE (In years last birthday) <u>56</u> yrs		10 UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
11b USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab Tech</u>		11b KIND OF BUSINESS OR INDUSTRY <u>Hosp. Lab</u>	
11 BIRTHPLACE (State or foreign country) <u>Stone Bridge, N.Y.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>HERBERT ALBERT MARSDEN</u>		14 MOTHER'S MAIDEN NAME <u>EVA DAVIS</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>219-36-0960</u>	
17 INFORMANT <u>Mt. Wilson Hosp Records</u>		Address <u>Mt. Wilson Md</u>	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Arteriosclerotic C-V. disease</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>2 yrs</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>none</u>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>none</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u> M.D.		22. DATE SIGNED <u>5-13-66</u>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES, M.D.</u>		DEPUTY MEDICAL EXAMINER <u>REKSTER, M.D.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>5-16-66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>St. James Cem.</u>		23d LOCATION (City or town) (County) (State) <u>Mt. Wilson Md.</u>	
24 FUNERAL DIRECTOR <u>Frank H. Young</u>		25 REC'D BY REG STRAR <u>MAY 20 1966</u>	
ADDRESS <u>Charles Judge</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



## CERTIFICATE OF DEATH

66473

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN TB <b>64 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKRIDGE</b>		d. STREET ADDRESS <b>5790 RACE ROAD</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JESSE CLARK, SR.</b>		4. DATE OF DEATH Month Day Year <b>MAY 15 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 27, 1898</b>
9. AGE (In years last birthday) yrs. <b>68</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE HELPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Armature Corp.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BERTIE CO., NO. CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ELIE CLARK</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA ANNE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-1</b>		16. SOCIAL SECURITY NO <b>215 05 7784</b>	
17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>151X CARCINOMA OF THE STOMACH WITH METASTASIS</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>WEEKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 12</b> 19 <b>66</b> , to <b>MAY 15</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>MAY 15</b> , 19 <b>66</b> , and that death occurred at <b>a. 12:30</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>A Sureshi</b>		22b. DATE SIGNED <b>5 15 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>AEDUL S. QURESHI, M.D.</b>		22d. ADDRESS <b>VET. ADM. HOSP., FT. HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/18/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b> 3035 W. North Ave. Baltimore, Md.		25a. REC'D BY REGISTRAR DATE <b>MAY 17 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

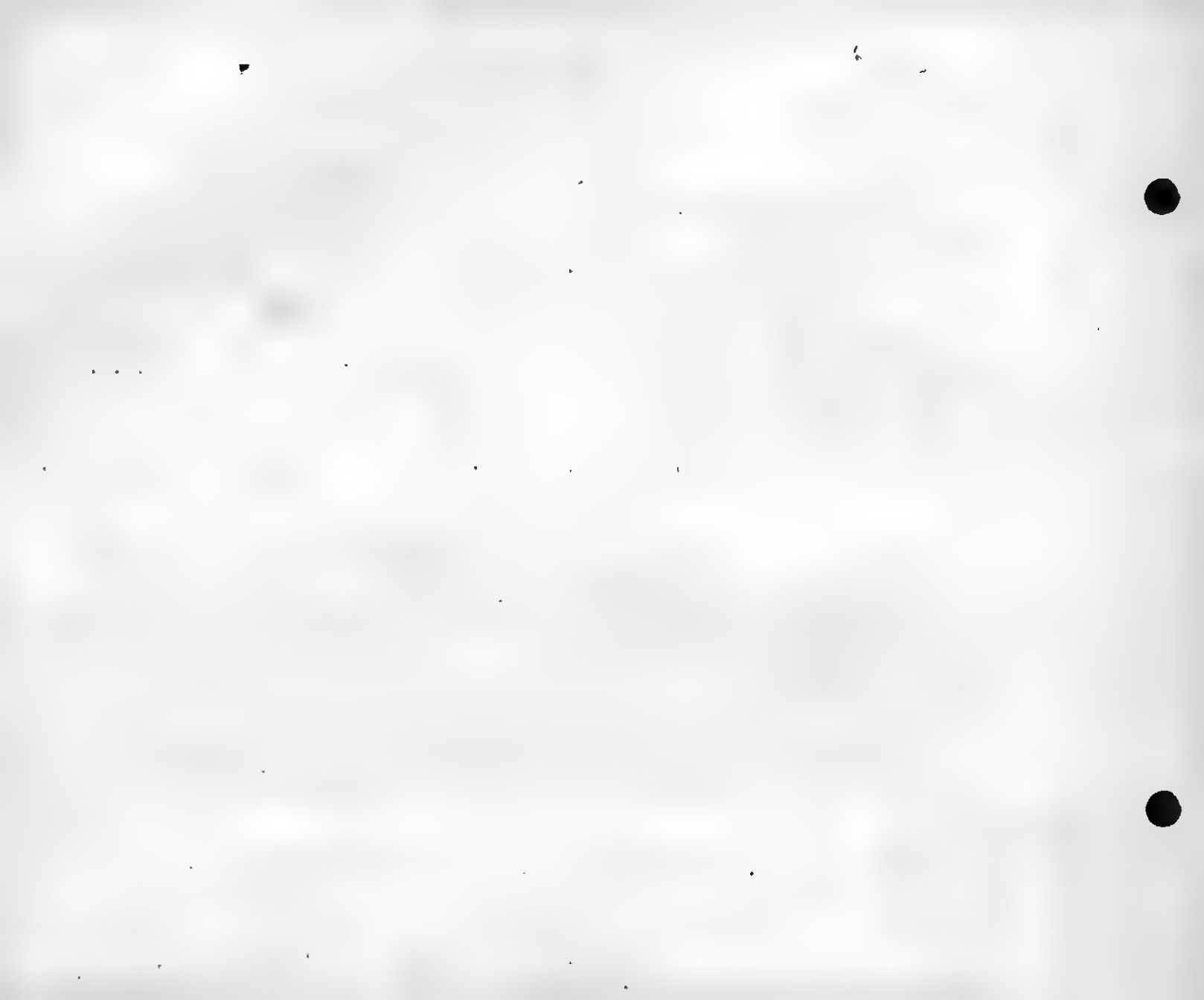
06476

06472

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>33 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PASADENA</b>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>B.</b> Last <b>CLEWS</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>13</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 5, 1920</b>
9. AGE (In years and birthday) <b>46 yrs</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>13</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COAL MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COAL</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BUCKRUN, PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH CLEWS</b>		14. MOTHER'S MAIDEN NAME <b>ELSIE BOWERS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>207 03 89 17</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO 5811 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>PULMONARY EDEMA AND CONGESTION</b> (c) <b>HEPATIC COMA</b> <b>LAENNEC'S CIRRHOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b> <b>RECENT</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>4/10/66</b> , 19__, to <b>5/13/66</b> , 19__, that (X) (we) last saw the deceased alive on <b>5/13/66</b> , 19__, and that death occurred at <b>12:15 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>George C. McElPatrick</i>		22b. DATE SIGNED <b>5/13/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE C. McELPATRICK, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5-16-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ODD FELLOWS CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>CENTRALIA PENNSYLVANIA</b>
24. FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME</b> <b>BALTIMORE, MARYLAND</b>		25. REC'D BY REGISTRAR <b>19 1966</b> <b>MT. CARMEL, PENNSYLVANIA</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>House # 12 Walnut St.</b>	
3 NAME OF DECEASED (Type or print) <b>William Paul Connors</b>		4. DATE OF DEATH <b>May 22 1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1900</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Marine Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York City</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Connors</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Rock</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>163-05-9907</b>	
17. INFORMANT <b>Mrs. Anna M. Connors</b>		Address <b>12 Walnut St. North East, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bilateral Pneumonia</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>May 17</b> , 19 <b>66</b> , to <b>May 22</b> , 19 <b>66</b> that <b>(X)</b> (we) last saw the deceased alive on <b>May 22</b> , 19 <b>66</b> , and that death occurred at <b>9:35 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Imre Kopits</b>		22b. DATE SIGNED <b>5/22/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Imre Kopits M.D.</b>		22d. ADDRESS <b>Spring Grove State Hosp. Catonsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/25/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary Anne's Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>North East, Md.</b>
24. FUNERAL DIRECTOR <b>Grant Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAY 25 1966</b>	
ADDRESS <b>Box 22 North East, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



18  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b> c. LENGTH OF STAY IN tb <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2114 Lodge Forest Drive</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b> d. STREET ADDRESS <b>2114 Lodge Forest Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Violet</b> Middle <b>L.</b> Last <b>Conrad</b>		4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1897</b>
9. AGE (In years last birthday) <b>69 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Besie Towers</b>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		15. SOCIAL SECURITY NO. <b>Ernest R. Conrad III E. William S. Salisbury, Md.</b>	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>ACHD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>(b)</b> <b>(c)</b>		17. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. TIME OF INJURY Month <b>5</b> Day <b>8</b> Year <b>1966</b> Hour <b>12:15</b> a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>	20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20d. (City or town) <b>Sgt Pt Md</b> (County) <b>md</b> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theodore C. Patterson</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Belair, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/11/66</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Gardens</b>		22d. LOCATION (City, town, or county) <b>Belair, Md.</b>	
23. FUNERAL DIRECTOR <b>Ullrich Funeral Home Dundalk Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 12 1966</b>	
24b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARYLAND</b> c. LENGTH OF STAY IN IT		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>701 Gun Road</b>		d. STREET ADDRESS <b>701 Gun Road</b>	
3. NAME OF DECEASED (Type or print) <b>Sister Mary of Lourdes Corse, O.S.P.</b>		4. DATE OF DEATH Month <b>5</b> Day <b>11</b> Year <b>1966</b>	
5. SEX <b>F</b> 6. COLOR OR RACE <b>Ne ro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>1/25/36</b> 9. AGE (In years last birthday) <b>80</b> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teaching</b> 11. BIRTHPLACE (County & State or foreign country) <b>Long Island, N. Y.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac Corse</b>		14. MOTHER'S MAIDEN NAME <b>Isabella Carpenter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Sister M. Magdalen, O.S.P.</b>		Address <b>701 Gun Road, Baltimore, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>4211</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Right Hemiplegia</b> DUE TO (c) <b>Left Carotid Artery Insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>3 days</b> <b>4 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 28, 1966</b> to <b>5/11, 1966</b> that (I) (we) last saw the deceased alive on <b>April 28, 1966</b> and that death occurred at <b>5/11, 1966</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Emidio A. Bianco</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Emidio A. Bianco, M.D.</b>		22d. ADDRESS <b>3350 Wilkens Ave.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/14/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph E. Clarkson</b>		25a. REC'D BY REGISTRAR <b>JUN 20 1966</b>	
ADDRESS <b>1129 N. Calver St</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



C6480

## CERTIFICATE OF DEATH

C6475

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>	
c. LENGTH OF STAY IN 1b <b>6 yrs.</b>		d. STREET ADDRESS <b>153 Church Lane</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>153 Church Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Walter Cogle</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 11, 1912</b>
9. AGE (In years last birthday) yrs. <b>54</b>		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cockeysville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles H. Cogle</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Barrett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-07-5696</b>	
17. INFORMANT <b>Mr. William M. Cogle</b>		Address <b>153 Church Lane</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH</b> 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>15 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 6, 1966</b> , to <b>MAY 13, 1966</b> , that (I) (we) last saw the deceased alive on <b>MAY 13, 1966</b> , and that death occurred at <b>6 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>William C. Rushing</i>		22b. DATE SIGNED <b>5-16-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. William A. Pillsbury</b>		22d. ADDRESS <b>2060 York Rd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-18-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Poplar Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Cockeysville, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson Inc.</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 23 1966</b>	
ADDRESS <b>1050 York Rd.</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.





VR A15 (4)  
20M 5-63

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>unknown</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Summit Nursing Home</b>		d. STREET ADDRESS <b>117 Raspe Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edgar</b>		4. DATE OF DEATH <b>5 31 1966</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARIED <input type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-21-1871</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Upholsterer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Francis Crebs</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-54-2177</b>		17. INFORMANT <b>Mr Howard Watts 4517 Raspe Avenue #6</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> <b>304X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Multiple Small Strokes</b> (c) <b>Chronic Brain Syndrome</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>new</b> <b>5 yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>10/25/63 5/31/66</b>	
20f. (City or town) <b>10/25/63 5/31/66</b>		20g. (County) <b>10/25/63 5/31/66</b>		20h. (State) <b>10/25/63 5/31/66</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>5/31/66</b> to <b>5/31/66</b> , that (I) <del>was</del> saw the deceased alive on <b>5/31/66</b> , and that death occurred at <b>450 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>W.E. McGrath M.D.</b>		22b. PHYSICIAN'S NAME (Type) <b>W.E. McGrath M.D.</b>		22c. DATE SIGNED <b>5/31/66</b>	
22d. ADDRESS <b>1303 Frederick Rd Catonsville</b>		22e. DATE SIGNED <b>5/31/66</b>		22f. DATE SIGNED <b>5/31/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-2-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Olivet Cemetery</b>	
23d. LOCATION (City, town or county) <b>Baltimore Co. Md.</b>		23e. LOCATION (City, town or county) <b>Baltimore Co. Md.</b>		23f. LOCATION (City, town or county) <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home 741 Belair Road</b>		24a. ADDRESS <b>741 Belair Road</b>		24b. REC'D BY REGISTRAR <b>JUN 3 1966</b>	
24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		24d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		24e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

VR A15 (4)  
20M 5-63



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06482

06477

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>6 months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Res., 7304 Dunbrook Court</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>7304 Dunbrook Court, 21222</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CURTIS</b> Middle <b>E.</b> Last <b>CULLISON, SR.</b>				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 31- 1895</b>	
9. AGE (In years) <b>70</b> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR TO 24 HRS. <input type="checkbox"/>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Cullison</b>				14. MOTHER'S MAIDEN NAME <b>Julia Trego</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>176-05-0887</b>		17. INFORMANT Address <b>Wife, Mrs. Frances A. Cullison, # 2, a, b, c, d.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the left lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Diabetes mellitus</b> DUE TO (c) <b>Arterio-sclerosis Cardiovascular disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-16</b> , 19 <b>66</b> , to <b>4-22-66</b> , that (I) (we) last saw the deceased alive on <b>5-22</b> 19 <b>66</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Eugene F. Navy</b>				22b. DATE SIGNED <b>May 23-1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Eugene F. Navy</b>				22d. ADDRESS <b>7001 Mornington Rd. Dundalk, Md. 21222</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 25-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION (City, town or county) (State) <b>Trumps Mill Rd. Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>				25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06483

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06478

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <b>Phoenix</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Dulaney Valley Road</b>		d. STREET ADDRESS <b>5 Glenn Brook Drive Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>PATRICK E. DAILEY</b>		4 DATE OF DEATH Month <b>5</b> Day <b>8</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7/18/44</b>
9 AGE (in years lost birthday) yrs <b>21</b>		10 UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT CAPITOL INST OF TECH.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE, MD.</b>	
11 BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12 CITIZEN OF WHAT COUNTRY? <b>ESTELLE YELTON</b>	
13 FATHER'S NAME <b>FRANK A. DAILEY</b>		14 MOTHER'S MAIDEN NAME <b>ESTELLE YELTON</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>FRANK A. DAILEY 5 GLENBROOK RD</b>	
17 INFORMANT <b>FRANK A. DAILEY 5 GLENBROOK RD</b>		Address	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple traumatic injuries with fracture of neck</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>8/6/4</b> (b) <b>XXXXX</b> (c) <b>DUE TO</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WHOLESALE PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>Auto-auto acc.</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Passenger in auto making left turn from Dulaney Valley Rd. onto Fox Chapel Road</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11:40</b> pm <b>5</b> <b>8</b> <b>1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>Road</b>		20f. (City or town) (County) (State) <b>Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>RUSSELL S. FISHER, M.D.</b>		22. DATE SIGNED <b>5-9-66</b>	
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MAY 12, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DULANEY VALLEY MEMO GARDENS, TIMONIUM MD.</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>H.W. MEARS &amp; SON 805 N. CALVERT ST</b>		25a. REC'D BY REGISTRAR <b>MAY 11 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



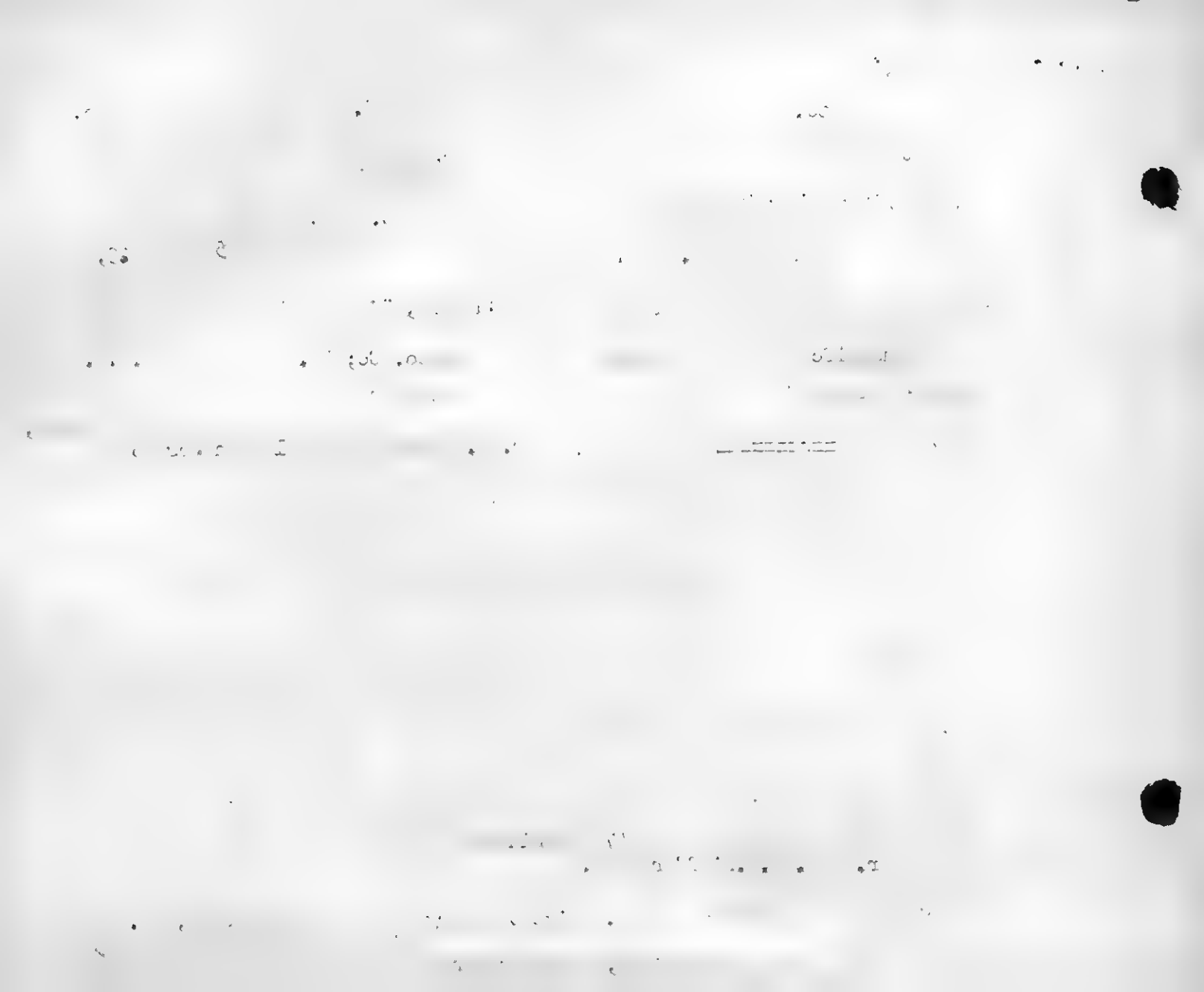
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN ID <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Forest Haven Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b> d. STREET ADDRESS <b>3518 St. James Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Katharine P. Damm</b>		4. DATE OF DEATH <b>May 23, 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years last birthday) <b>75 yrs.</b>
11. BIRTHPLACE (State or foreign country) <b>Balto. Co; Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Stierhoff</b>		14. MOTHER'S MAIDEN NAME <b>Emma Bunn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If give war or dates of service)</b>	
17. INFORMANT <b>Mr. H. Lurman Damm</b>		Address <b>Randallstown, Md. 3712 Lanamer Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO (b) <b>Pneumonia Cardiovascular Disease</b> DUE TO (c) <b>accident fracture right femur</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Had a fall on floor at Nursing Home</b>	
20c. TIME OF INJURY Month, Day, Year <b>? Hour a.m. 4-6 p.m. 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>Forest Haven Nursing Home</b>		20f. (City or town) <b>Catonsville</b> (County) <b>Bal Co</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. Geo. S.M. Kieffer</b>		22. DATE SIGNED <b>May 24/66</b>	
EXAMINER'S NAME (Type) <b>Dr. Geo. S.M. Kieffer Blvd.</b>		Address (Street, city, town, or county) <b>2470 Washington M.D. Rockdale</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/26/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Randallstown, Md.</b>	
24. FUNERAL DIRECTOR <b>LORING BYERS</b>		25a. REC'D BY REGISTRAR <b>MAY 26 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

66485

66480

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore Co</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>		c. LENGTH OF STAY IN 1b <b>one year</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>			d. STREET ADDRESS <b>8 Lincoln Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Daniel</b> Last <b>Daniel</b>			4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1966</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9, 1912</b>	9. AGE (In years last birthday) <b>53 yrs.</b>	10. FUNDER 1 YEAR Months <b>53</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>	
13. FATHER'S NAME <b>Charlie Daniel</b>			14. MOTHER'S MAIDEN NAME <b>Elizian Bell</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>252-69-8463</b>		17. INFORMANT <b>Hosp. records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis</b> DUE TO (b) <b>22 years</b> DUE TO (c) <b>22 years</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>22 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>5.7</b> , 19 <b>65</b> to <b>5.3</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5.3</b> , 19 <b>66</b> , and that death occurred at <b>6:50</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Wm. Newcomer</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5.3.66</b>
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>			22d. ADDRESS <b>Mount Wilson, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/7/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>West Liberty Cemetery</b>	23d. LOCATION (City, town or county)	(State)	<b>Md.</b>
24. FUNERAL DIRECTOR <b>Herbert C. Mutter - 3035 W. North Ave - Mt</b>			25a. REC'D BY REGISTRAR <b>MAY 9 1966</b>		
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



FOR STATE  
HEALTH DEPT.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C6486

C6481

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>Baltimore</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH'S HOSPITAL</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admision) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1261 E. Belvedere Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WALTER C. DARMODY</b>		4 DATE OF DEATH Month <b>5</b> Day <b>14</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 4, 1894</b>
9 AGE (In years lost birthday) yrs. <b>71</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>14</b> Hours <b>19</b> Min <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio</b>	
11 BIRTHPLACE (State or foreign country) <b>Ohio</b>		12 COUNTRY OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Darmody</b>		14. MOTHER'S MAIDEN NAME <b>Josephine O'Donnell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Mrs. Teresa C. Darmody</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple traumatic injuries</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Pedestrian struck by auto on Belvedere Ave., 88' W. of Woodmount Avenue</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>9:30</b> p.m. <b>5-11</b> 19 <b>66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	
20f. (City or town) <b>Baltimore</b>		(County) <b>Baltimore</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Russell S. Fisher</i>		22. DATE SIGNED <b>5-16-66</b>	
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/18/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., Balto., Md. 21214</b>		25a. REC'D BY REG. STRAR <b>MAY 17 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in an unopened envelope within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06487

06482

1. PLACE OF DEATH a. CITY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>11 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>903 SUNSET STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>--</b> Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>25</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 29, 1888</b>
9. AGE (In years last birthday) yrs. <b>78</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ALVILLE, SOUTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MENACE DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>ANGIE MN: UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO <b>219 01 52 41</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4200</b> DUE TO <b>CARDIAC INSUFFICIENCY</b>			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> (c) DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b>			<b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (1) this hospital attended the deceased from <b>5/14/66</b> , 19__, to <b>5/25/66</b> , 19__, that (2) (we) last saw the deceased alive on <b>5/25/66</b> , 19__, and that death occurred <b>2:25A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Neilson</i>		22b. DATE SIGNED <b>5/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILON NEILSON, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-27-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>C.O. Wilson</b>		25a. REC'D BY REGISTRAR <b>ELROY O. WILSON FUNERAL HOME</b> DATE <b>5/27/66</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

06488

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06483

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY N 1b <b>Perry Hall</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall</b> d. STREET ADDRESS <b>156 Forge Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>IRMA Regina DAWSON</b>				4. DATE OF DEATH Month Day Year <b>5 15 19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-11-1924</b>	
9. AGE (In years last birthday) yrs <b>42</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Sparrows Point Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Theodore Bissell</b>			
14. MOTHER'S MAIDEN NAME <b>Carey Appel</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO <b>212-16-1864</b>				17. INFORMANT Address <b>Harry A. Dawson 156 Forge Road 21128</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Crushing injuries of chest</b> 983x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>Run over by car</b>			
20c. TIME OF INJURY Month, Day, Year <b>4:15 p.m. 5 15 19 66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Road</b>		20f. (City or town) (County) (State) <b>Perry Hall Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher</b> EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>				22. DATE SIGNED <b>5-16-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-19-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Fiath Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road</b>				ADDRESS <b>(36)</b>		25a. REC'D BY REGISTRAR <b>WAY 19 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06489

06484

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN b <b>5dys</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b> d. STREET ADDRESS <b>1126 "H" Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>George</b> Last <b>De Arment</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 20, 1887</b>
9. AGE (in years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>steelworker, retired Bethlehem Steel</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Co. Penna.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Anthony De Arment</b>		14. MOTHER'S MAIDEN NAME <b>Ida Griffith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO <b>213-07-5199</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Advanced, generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <b>May 10, 19 66</b> to <b>May 15, 19 66</b> that (b) (we) last saw the deceased alive on <b>May 15, 19 66</b> , and that death occurred at <b>8:40</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b>		22b. DATE SIGNED <b>5-16-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 18-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Rock Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Lewistown, Mifflin Co. Penna.</b>
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 18 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>g Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. LENGTH OF STAY IN 1b <b>Maryland</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>						d. STREET ADDRESS <b>7914 Hillendale Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Napoleon</b> Middle <b>DiStefano</b> Last <b>DiStefano</b>						4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-10-1903</b>		9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Toolmaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Martin Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Luigi DiStefano</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>212-03-4086</b>		17. INFORMANT <b>Ida A. DiStefano (As Above)</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of liver with widespread metastasis.</b> 1061 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 5, 1966</b> to <b>May 6, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 6, 1966</b> , and that death occurred at <b>8:25 p.m.</b> from the causes and on the date stated above.											
22a. SIGNATURE <i>Theodulo J. Paglinauan</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>May 6, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Theodulo J. Paglinauan, M.D.</b>						22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/9/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Raymond C. Fink</b>						ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 10 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Golden Ring</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Golden Ring</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7140 Golden Ring Road</u>					d. STREET ADDRESS <u>7140 Golden Ring Road</u>				
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u></u> Last <u>Dohler</u>					4. DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-26-1902</u>		9. AGE (In years last birthday) <u>63</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Zion Church</u>		11. BIRTHPLACE (State or foreign country) <u>Balto, Co. Maryland</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13. FATHER'S NAME <u>Louis Dohler</u>					14. MOTHER'S MAIDEN NAME <u>Mary Hilmer</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>217-01-3232</u>		17. INFORMANT Address <u>Mrs Catherine Dohler 7140 Golden Ring Road</u>		
18. CAUSE OF DEATH (Enter only one cause possible for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>4201</u> DUE TO <u>ACHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u></u> (c) <u></u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year <u>3</u> Hour <u>5</u> a.m. <u>5/19/66</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Golden Ring</u> (County) <u>Balto</u> (State) <u>Md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
SIGNATURE <u>Theo C. Patterson</u> EXAMINER'S NAME (Type) <u>Theo. C. Patterson, M. D.</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Golden Ring Balto. Co. Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-22-1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Golden Ring Balto. Co. Md.</u>		
23. FUNERAL DIRECTOR <u>Lassala Funeral Home 7401 Belair Road</u>					24a. REC'D BY REGISTRAR <u>MAY 23 1966</u>				
					24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The deceased remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b></b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>					c. LENGTH OF STAY IN 1b <b></b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>College Manor, Inc.</b>					d. STREET ADDRESS <b>3023 St. Paul St.</b>				
3. NAME OF DECEASED (Type or print) <b>May Lee Willis Downey</b>					4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 25, 1881</b>		9. AGE (In years last birthday) <b>84</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kent Co., Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b></b>		
13. FATHER'S NAME <b>Thomas J. Willis</b>					14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Chaplain</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b></b>				
17. INFORMANT <b>Mr. William Downey 226 Homewood Terr.</b>					Address <b></b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>									INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b></b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1950</b>		20f. (City or town) (County) (State) <b>May 1966</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>May 1966</b> , that (I) (we) last saw the deceased alive on <b>May 20, 1966</b> , and that death occurred at <b>8</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. William G. Helfrich</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>May 23, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. William G. Helfrich</b>					22d. ADDRESS <b>5006 Roland Ave. Baltimore, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-23-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>			23d. LOCATION (city, town or county) (State) <b>Pikesville, Maryland</b>		
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212</b>					25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>g Charles Judge</b>		





66493

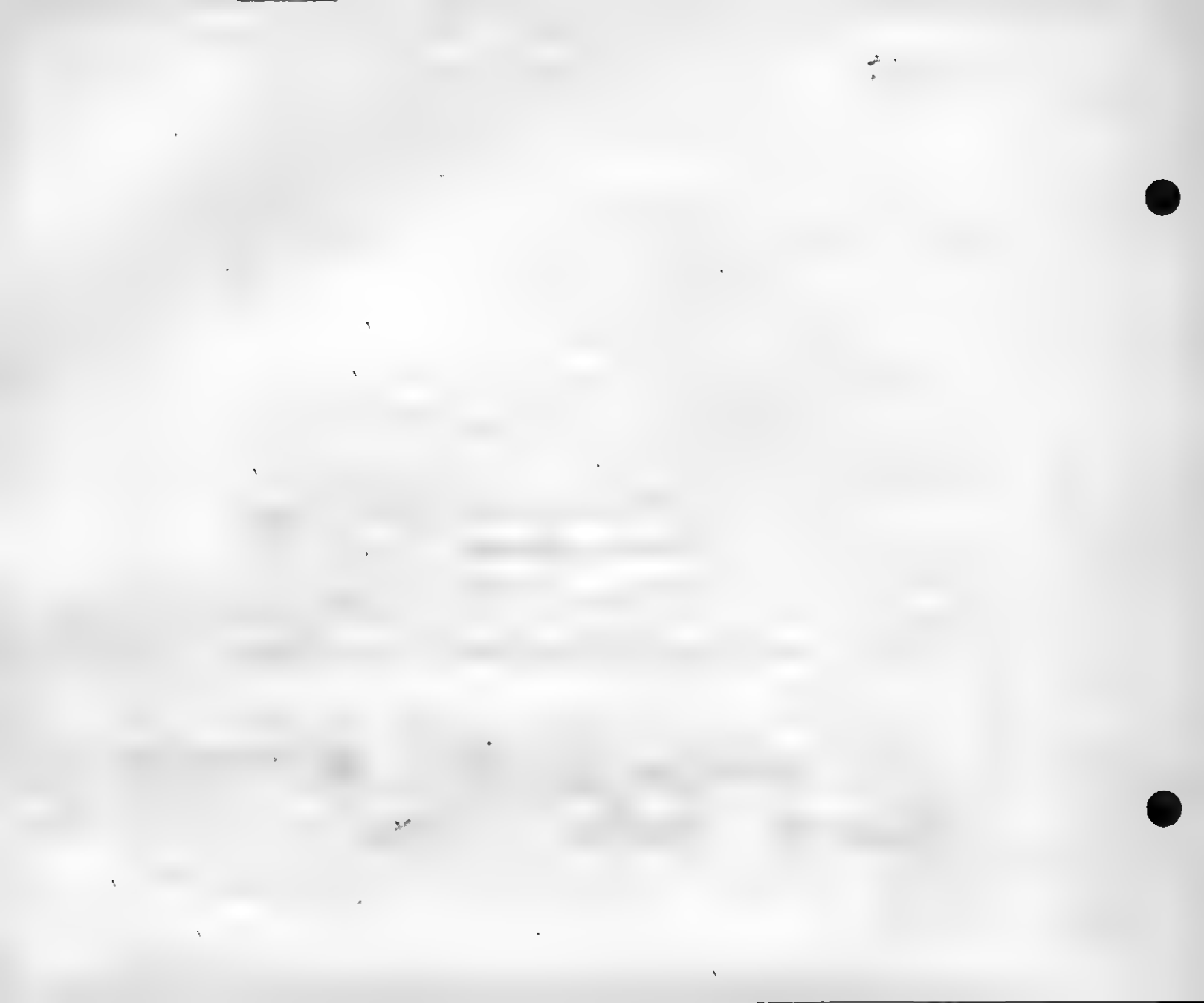
CERTIFICATE OF DEATH

66488

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE HIGHLANDS</b>		c. LENGTH OF STAY IN 1b <b>21227</b>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>BALTIMORE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE HIGHLANDS</b>		d. STREET ADDRESS <b>2906 VIRGINIA AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>REGINA</b>		First		Middle		Last <b>DOWNEY</b>		4. DATE OF DEATH <b>MAY</b>		Month		Day <b>28</b>		Year <b>19 66</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 11, 1898</b>		9. AGE (in years last birthday) <b>68 yrs</b>		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS Days		12. IF UNDER 24 HRS Hours					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>-----ALLERS</b>		14. MOTHER'S MAIDEN NAME <b>MARM JANE-----</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-07-2783D</b>		17. INFORMANT <b>MRS. REGINA SCHATZ, 2906 VIRGINIA AVENUE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis C.V.D.</b> DUE TO (c) <b>Arteriosclerosis</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Asc - cerebrovascular disease</b>		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 19 <b>62</b> to <b>May</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>5/30</b> , 19 <b>66</b> and that death occurred at <b>3:4</b> M, from causes and on the date stated above.		22a. SIGNATURE <b>George Vash</b>		22b. DATE SIGNED <b>5/30/66</b>		22c. PHYSICIAN'S NAME (Type) <b>GEORGE VASH</b>		22d. ADDRESS <b>206 SOUTH GILMORE STREET, 21223</b>		23a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-1-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME, 4107 WILKENS AVENUE</b>		25a. REC'D BY REGISTRAR <b>JUN 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		25c. ADDRESS		25d. REC'D BY REGISTRAR		25e. REGISTRAR'S SIGNATURE		25f. ADDRESS		25g. REC'D BY REGISTRAR		25h. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



06494

## CERTIFICATE OF DEATH

06489

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. LENGTH OF STAY IN lb <b>3 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Lynncrest Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BRUCE MILTON DUNHAM</b>		4. DATE OF DEATH Month <b>May</b> Day <b>21</b> , Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1909</b>
9. AGE (In years lost birthday) <b>56</b> yrs.		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice. Pres.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>oil</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>M. Raymond Dunham</b>		14. MOTHER'S MAIDEN NAME <b>Hazel Smathers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W. Two</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mrs. Elizabeth Ann Dunham, Same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>+201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) <b>Coronary arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 min.</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 5, 1964</b> to <b>May 21, 1966</b> that (I) (we) last saw the deceased alive on <b>May 12, 1966</b> and that death occurred at <b>10 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>C. Holmes Boyd</b>		22b. DATE SIGNED <b>5/21/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. Holmes Boyd, M.D.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 24, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Baltimore, Md.</b>
24. ATTENDING PHYSICIAN <b>Wm. Cook-Brooks Towson, Maryland</b>		25. REC'D BY REGISTRAR <b>MAY 25 1966</b>	
26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06495

06490

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>39 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>821 - 5TH AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>RICHARD</b> Last <b>DYSARD</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>9</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-29-04</b>
9. AGE (In years last birthday) yrs <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PORTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TAVERN</b>	11. BIRTHPLACE (County & State, or foreign country) <b>HUNTINGDON, PENN</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>GEORGE T. DYSARD</b>	
14. MOTHER'S MAIDEN NAME <b>AGNES REAM</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>	
16. SOCIAL SECURITY NO <b>176 10 79 12</b>		17. INFORMANT <b>VA HOSPITAL</b> Address <b>FORT HOWARD, MARYLAND (CLINICAL RECORDS)</b>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>163X CARCINOMA OF LEFT LUNG WITH METASTASIS TO LIVER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A TOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from <b>MARCH 31, 1966</b> , to <b>MAY 9, 1966</b> , that (A) (we) last saw the deceased alive on <b>MAY 9, 19 66</b> , and that death occurred at <b>1230 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>J. D. Talbert</i>		22b. DATE SIGNED <b>5/9/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>May 12, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>George J. Gonce</b>		25a. REC'D BY REGISTRAR <b>MAY 11 1966</b> DATE <b>Ritchie Highway, Baltimore, Md.</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06496

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06491

1 PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape May</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape May</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1722 Ann Ave.</u>		d. STREET ADDRESS <u>1722 Ann Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>O</u> Last <u>ECCLESTON</u>		4 DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 3, 1911</u>
9 AGE (In years last birthday) <u>54</u> yrs		10 IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11 IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
3 FATHER'S NAME <u>  </u>		14 MOTHER'S M.A.D.E.N. NAME <u>  </u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17 INFORMANT <u>Wife (Same as above)</u>		Address <u>  </u>	
18 CAUSE OF DEATH (Enter only one cause per line (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Acute Coronary Occlusion</u> (c) <u>Coronary Artery Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>  </u>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>		(County) <u>  </u>	
(State) <u>  </u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <u>5/31/66</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Theo C. Patterson</u> M.D. EXAMINER'S NAME (Type) <u>THEO C. PATTERSON</u>		Address (Street, city, town, or county) <u>  </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/1/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	23d. LOCATION (City or Town) <u>Balto. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Connolly Sons</u>		25a. REC'D BY REGISTRAR <u>JUN 1 1966</u>	
ADDRESS <u>300 Race Ave. Balto.</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>10</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph's Hospital</u>						e. STREET ADDRESS <u>6702 Bessemer Avenue</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>James</u>		Middle <u>Albert</u>		Last <u>ECKMAN</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1966</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-8-87</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Eckman</u>						14. MOTHER'S MAIDEN NAME <u>Mary Tormay</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Mrs. Ida Eckman</u>		Address <u>6702 Bessemer Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease</u> <u>460X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Diabetic Gangrene, Right Foot</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 29</u> , <u>66</u> to <u>May 5</u> , <u>1966</u> , that (I) (we) last saw the deceased alive on <u>May 5</u> , <u>1966</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Lesdon R. Canangel</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>5-5-66</u>	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/10/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Scottdale, Pa.</u>			
24. FUNERAL DIRECTOR <u>Ullrich Funeral Home Dundalk, Md.</u>						25a. REC'D BY REGISTRAR <u>MAY 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06498

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06493

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BEL AIR</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b> <b>IN AMBULANCE ON WAY TO HOSPITAL</b>		d. STREET ADDRESS <b>Rte 3 Grafton Shop Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>HERBERT H. ELLER</b>		4 DATE OF DEATH Month <b>MAY</b> Day <b>15</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-24-22</b>
9. AGE (In years last birthday) <b>43</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>15</b> Hours <b>15</b> Min	11. IF UNDER 24 HRS Hours <b>15</b> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machine Mfg.</b>	
11. BIRTHPLACE (State or foreign country) <b>Ashe County, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Washington Eller</b>		14. MOTHER'S MAIDEN NAME <b>Luvenia Seagraves</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>216-16-0744</b>	
17. INFORMANT <b>Vada M. Eller</b>		RD #3 Address <b>Box 404</b> <b>Bel Air, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>15 MIN</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William A. Pilsbury</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William A. Pilsbury</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>5-15-66</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/19/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Mem. Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Bel Air, Maryland</b>
24. FUNERAL DIRECTOR <b>Charles E. Kutz</b>		25a. REC'D BY REGISTRAR <b>May 18 1966</b>	
ADDRESS <b>Jarrettsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #1277 6/3/66

## CERTIFICATE OF DEATH

06499

06494

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and ~~completely~~ filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>		d. STREET ADDRESS <b>808 Ridgeleigh Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Clara A. Emerson</b>		4. DATE OF DEATH Month <b>May</b>		Day <b>30</b>		Year <b>19 66</b>		5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/7/1840</b> AGE (In years last birthday) <b>86</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William E. Adamson</b>		14. MOTHER'S MAIDEN NAME <b>Ann E. Cole</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>152-07-3926</b>	
17. INFORMANT <b>Charles E. Emerson</b>		Address <b>(Same)</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-Vascular Disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Court</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>1953</b> , 19 to <b>May</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 27</b> , 19 <b>66</b> , and that death occurred at <b>7:10 A.M.</b> from causes and on the date stated above.		22a. SIGNATURE <b>Loy M. Zimmerman</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/31/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Loy M. Zimmerman M.D.</b>		22d. ADDRESS <b>3202 Harford Rd. Baltimore, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial</b>		23b. DATE THEREOF <b>6/2/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Wash. Mem. Pk.</b>		23d. LOCATION (City or Town) (County) (State) <b>Paranus N.J.</b>		24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>					
25a. REC'D BY REGISTRAR DATE <b>MAY 31 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S NAME <b>Charles Judge</b>		25d. REGISTRAR'S ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>		25e. REGISTRAR'S PHONE <b>4905 York Rd. Balto. 12, Md.</b>		25f. REGISTRAR'S TELETYPE <b>4905 York Rd. Balto. 12, Md.</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06500

## CERTIFICATE OF DEATH

06495

1. PLACE OF DEATH a. COUNTY Baltimore (Woodlawn) MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Woodlawn				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Woodlawn			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6619 Dogwood Rd.				d. STREET ADDRESS 6619 Dogwood Rd.			
3. NAME OF DECEASED (Type or print) First Middle Last Freida H Emrich				4. DATE OF DEATH Month Day Year May 17 1966			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1897		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME August Haupt				14. MOTHER'S MAIDEN NAME Lena Stage			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Schmidt, (Niece) 6621 Dogwood Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Acute congestive cardiac failure Arteriosclerotic Heart disease							INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1956 to 1966, 19..., that (I) (we) last saw the deceased alive on 5/15/66 19..., and that death occurred at 2 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Milton Schlenoff				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Dr. Milton Schlenoff	
22d. ADDRESS 6400 Windsor Mill Rd.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5/21/66		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James A. Bunnside				24a. ADDRESS 1415 N. Balto. St.		25a. REC'D BY REGISTRAR MAY 24 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06501

## CERTIFICATE OF DEATH

06496

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>9mth 3dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>7408 - 83rd Place</b>	
3. NAME OF DECEASED (Type or print) First <b>Milton</b> Middle <b>T.</b> Last <b>Engle</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1899</b>
9. AGE (In years last birthday) <b>66</b> yrs		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>2</b>	11. IF UNDER 24 HRS. Hours <b>16</b> Min. <b>2</b>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Milton</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ketler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown No</b>		16. SOCIAL SECURITY NO <b>714-07-9040</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular disease</b> <b>4 2 2 1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Pulmonary emphysema</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Amputation of left leg; above-knee</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>Aug. 24, 1965</b> , to <b>May 27, 1966</b> , that (I) <b>(X)</b> (he) last saw the deceased alive on <b>May 27, 1966</b> , and that death occurred at <b>4:00 P.</b> M, from causes on and the date stated above.			
22a. SIGNATURE <b>Stella Wachsler, M.D.</b> M.D.		22b. DATE SIGNED <b>5-27-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachsler</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/31/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wash. Nat. Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>
24. FUNERAL DIRECTOR <b>Halley's Funeral Home Inc.</b>		25. REC'D BY REGISTRAR <b>JUN 2 1966</b>	
ADDRESS <b>Mt. Rainier Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 06497

06502

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shady Nook Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>M.</u> Last <u>ESSIG</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>23</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-1890</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min <u>15</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilmington, Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Fowler</u>		14. MOTHER'S MAIDEN NAME <u>Hines</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>316-28-9638</u>	
17. INFORMANT <u>Howard A. Essig - 4803 Norwood Ave</u>		Address <u>4803 Norwood Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO <u>Arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Arterio sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary fibrillation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/26</u> , 19 <u>62</u> to <u>5/23</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>5/23</u> , 19 <u>66</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>4710 Liberty Hts Ave</u> DATE SIGNED <u>5/24/66</u>	
PHYSICIAN'S NAME (Type) <u>DR. LEE J. VOLENICK</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-26-66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ELLsworth Armacost</u>		ADDRESS <u>4600 Liberty Hts Ave</u>	
24a. REC'D BY REGISTRAR <u>MAY 26 1966</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

C6503

C6498

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Armagh Village</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7003 Bellona Avenue</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Armagh Village</b> d. STREET ADDRESS <b>7003 Bellona Ave. 12</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Emma</b> Middle <b>M.</b> Last <b>Ewalt</b>		<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>8</b> Year <b>1966</b>		<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Feb. 13, 1880</b>		<b>9. AGE</b> (In years last birthday) <b>86</b> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>													
<b>13. FATHER'S NAME</b> <b>Charles N. Merritt</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Kate Lynch</b>															
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>217-48-4774</b>		<b>17. INFORMANT</b> <b>Mrs. Mary E. Appleby same address as above</b>				<b>Address</b>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>157X</b> DUE TO <b>Carcinoma of the Pancreas</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>10 Months</b>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)																
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>														
<b>21. I certify that (I) (this hospital) attended the deceased from <u>December, 1950</u>, to <u>May 8, 1966</u>, that (I) (we) last saw the deceased alive on <u>May 8, 1966</u>, and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.</b>																					
<b>22a. SIGNATURE</b> <b>W. Grafton Hersperger</b>								<b>22b. DATE SIGNED</b> <b>5/9/66</b>													
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>W. Grafton Hersperger, M. D.</b>						<b>22d. ADDRESS</b> <b>214 Medical Arts Building</b>															
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>5/10/1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Druid Ridge Cemetery</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Pikesville, Md.</b>															
<b>24. FUNERAL DIRECTOR</b> <b>Wm. J. Fickner &amp; Sons</b>						<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAY 10 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
06504 CERTIFICATE OF DEATH 06499

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>CENTER</u> <u>GREATER BALT MED</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> <u>BALTIMORE</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALT MED CENTER</u>		d. STREET ADDRESS <u>608 E 27th Street</u>	
3. NAME OF DECEASED (Type or print) First <u>NELSON</u> Middle <u>L.</u> Last <u>FAGAN</u>		4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/10/04</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUN CAB CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHAUFFEUR</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ELLICOTT CITY</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>EUGENE FAGAN</u>		14. MOTHER'S MAIDEN NAME <u>ROSE FRANCE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-03-504</u>	
17. INFORMANT <u>Pt's History</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u> <u>4200</u> DUE TO <u>ARTERIO-SCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY THROMBOEMBOLISM</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/4</u> , 19 <u>66</u> , to <u>5/12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/12</u> 19 <u>66</u> , and that death occurred at <u>4:05</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>5/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>LARRY CHONG</u>		22d. ADDRESS <u>GREATER BALT MED CENTER</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-14-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GOOD SHEPHERD</u>		23d. LOCATION (City, town or county) (State) <u>ELLICOTT CITY MD.</u>	
24. FUNERAL DIRECTOR <u>F.C. HIGINBOTHAM</u>		25a. REC'D BY REGISTRAR <u>May 16 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S NAME <u>John Charles Judge</u>	





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# MARYLAND STATE DEPARTMENT OF HEALTH

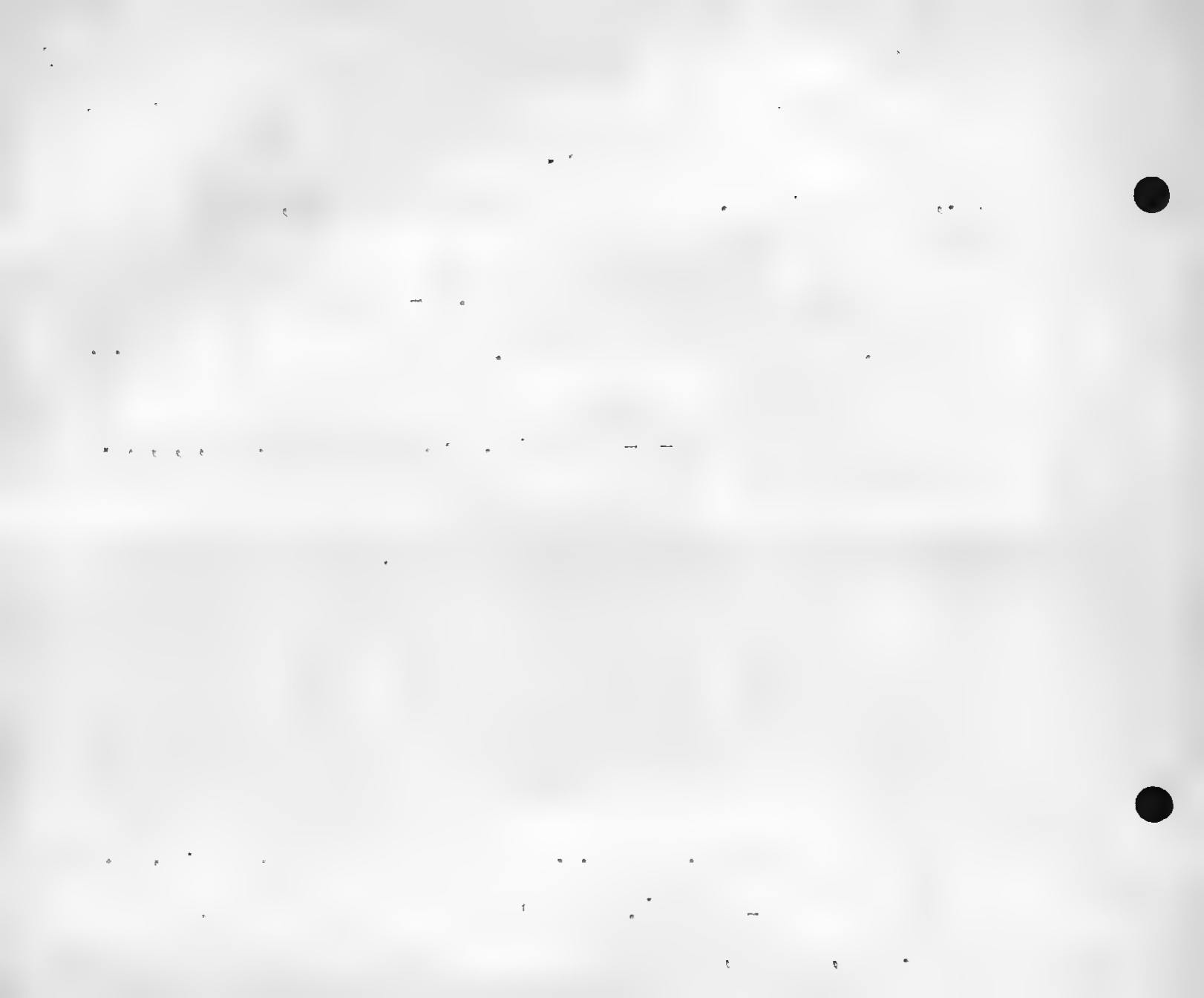
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06505

06500

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			
c. LENGTH OF STAY IN 1b <b>38 yrs.</b>				d. STREET ADDRESS <b>6807 Dunhill Road, 21222</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Res., 6807 Dunhill Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>JOSEPH</b> Middle <b>FALL</b> Last <b>FALL</b>		4. DATE OF DEATH		Month <b>May</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 17- 1884</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	IF UNDER 24 HRS. Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired,</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andy Fall</b>				14. MOTHER'S MAIDEN NAME <b>Annie Misteczski</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-0314</b>		17. INFORMANT Address <b>Wife, Mrs. Kathryn Fall, # 2, a, b, c, d.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Hypertension with arteriosclerosis cordis</b> DUE TO <b>Wascular disease.</b> (c) <b>Cardiac insufficiency.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1964</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-8-64</b> , 19 <b>64</b> , to <b>5-28</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-28</b> , 19 <b>66</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Eugene F. Nevy</b>				22b. DATE SIGNED <b>May 29-1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Eugene F. Nevy M.D.</b>				22d. ADDRESS <b>7001 Mornington Rd. Dundalk, Md. 21222</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 31-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Church Cemetery, Dundalk, Maryland</b>		23d. LOCATION (City, town or county) (State) <b>21222</b>	
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>				25a. REC'D BY REGISTRAR <b>JUN 2 1966</b>			
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06506						06501					
Item 2 Film 03/7 6/2/66 md											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN ID <b>MD</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTRE</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>BALTIMORE</b> b. COUNTY <b>MD</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 34</b> d. STREET ADDRESS <b>1826 Berrywood Rd. 6701 N. CHARLES ST. BALTO.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JOSEPH DOMINIC FERRARA</b>						4. DATE OF DEATH <b>May 29 1966</b>					
5. SEX <b>M</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <b>10. 21. 22</b> 9. AGE (In years last birthday) <b>43</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>CORR. OFFICER State of Md.</b>						11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD</b>					
13. FATHER'S NAME <b>Samuel Ferrara</b>						14. MOTHER'S MAIDEN NAME <b>Margianne De Campo</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW2</b>						16. SOCIAL SECURITY NO. <b>215-18-9084</b>					
17. INFORMANT <b>Rose M. Ferrara</b>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERPYREXIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) <b>INTERCURRENT INFECTIONS</b> DUE TO (c) <b>AGRANULOCYTOSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>LYMPHO SARCOMA WITH SEVERE ANAEMIA</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>X</b>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>X</b>						20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19 X</b>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>X</b>					
20f. (City or town) <b>X</b> (County) (State)						21. I certify that (I) (this hospital) attended the deceased from <b>4. 9. 1966</b> to <b>5. 29. 1966</b> that (II) (we) last saw the deceased alive on <b>5. 29. 1966</b> , and that death occurred at <b>11.30 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Ramesh C. AGARWAL M.D.</b>						22b. DATE SIGNED <b>JUN 1 1966</b>					
22c. PHYSICIAN'S NAME (Type) <b>RAMESH C. AGARWAL</b>						22d. ADDRESS <b>6701, N. CHARLES ST. BALTO.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						23b. DATE THEREOF <b>6/2/66.</b>					
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>						23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>						25a. REC'D BY REGISTRAR <b>JUN 1 1966</b>					
						25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7714 Bagley Ave.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>7714 Bagley Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>V.</u> Last <u>Fink</u>			4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1966</u>								
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-11-1884</u>		9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Brown</u>					14. MOTHER'S MAIDEN NAME <u>Emma Brown</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>216321400</u>		17. INFORMANT <u>Leonard W. Fink</u>			Address <u>3008 Woodside Ave.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Cerebral Arteriosclerosis</u> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>20 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>May 12, 1966</u> to <u>May 15, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 15, 1966</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE <u>[Signature]</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>S. Elliott Harris M.D.</u>					22d. ADDRESS <u>8100 Harford Rd. 21234</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>5-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>				
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>						25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



## CERTIFICATE OF DEATH

C6503

C6503

1. PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>BALTIMORE</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c LENGTH OF STAY IN 1b <b>31 DAYS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d STREET ADDRESS <b>923 BURGUNDY STREET</b>	
3 NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>EARL</b> Last <b>FISHER</b>		4 DATE OF DEATH Month <b>MAY</b> Day <b>15</b> Year <b>1966</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6/13/13</b>
9 AGE (In years last birthday) yrs <b>52</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BRAKEMAN</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		11 BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>WILLIAM E. FISHER</b>	
14 MOTHER'S MAIDEN NAME <b>BLANCHE JOHNSON</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>	
16 SOCIAL SECURITY NO <b>217 09 65 49</b>		17 INFORMANT <b>CLINICAL RECORDS</b> <b>V.A. HOSPITAL, FT. HOWARD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PROBABLE ACUTE MYOCARDIAL INFARCTION</b> DUE TO (c) <b>ARTERIO-SCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>MINUTES</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/14/66</b> , 19 <b>66</b> to <b>5/15/66</b> , 19 <b>66</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>5/15/66</b> , 19 <b>66</b> , and that death occurred on <b>5/15/66</b> at <b>12:21 A.M.</b> from causes and on the date stated above.			
22a SIGNATURE <b>ABDUL S. QURESHI, M.D.</b>		22b. DATE SIGNED <b>5/15/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ABDUL S. QURESHI, M.D.</b>		22d ADDRESS <b>V.A. HOSPITAL, FT. HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5-19-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE 28, MARYLAND</b>
24 FUNERAL DIRECTOR <b>ISAIAH L. BROWN &amp; SON, FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>MAY 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S NAME <b>CHARLES JUDGE</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

— 22 —

6. The following table shows the results of the regression analysis for the dependent variable "Number of children" (N = 1,000).

1

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2000



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06509

06504

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.-rural</b>		c. LENGTH OF STAY IN 1b <b>Monkton (Balto.-rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>John P. Fiske</b>		4 DATE OF DEATH Month Day Year <b>5 30 19 66</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April-7-1966</b>
9 AGE (In years last birthday) yrs <b>1</b> Months <b>21</b> Days <b>21</b> Hours <b>19</b> Min. <b>66</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>none</b>		11 BIRTHPLACE (State or foreign country) <b>(Balto.Co.) Greater Balto. Med. Center</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13 FATHER'S NAME <b>C. Stewart Fiske Jr.</b>	
14 MOTHER'S MAIDEN NAME <b>Barbara L2 Derrickson</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16 SOCIAL SECURITY NO. <b>none</b>		17 INFORMANT <b>C.S. Fiske, 3906 Hadley Square, W. 21218</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial pneumonitis</b> 525X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bilateral purulent otitis media</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		22. DATE SIGNED <b>5/31/66</b>	
23a BURIAL, CREMATION REMOVAL (Specify) <b>burial</b>		23b DATE THEREOF <b>June-2-66</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Pikesville, Balto. Co. 21208</b>	
24 FUNERAL DIRECTOR <b>Stewart &amp; Mowen Co-108-N-North-Av 21201</b>		25a BY REGISTRATION <b>JUN 3 1966</b> 25b REGISTRAR'S SIGNATURE <i>James Judge</i>	



CERTIFICATE OF DEATH

06510

06505

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> c. LENGTH OF STAY IN 1b <b>26 yrs.</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>		d. STREET ADDRESS <b>8348 Kavanagh Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Christian</b> Middle <b>Ernest</b> Last <b>FLOYD</b>		4 DATE OF DEATH Month <b>5-</b> Day <b>20</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-29</b>
9 AGE (In years lost birthday) <b>37</b> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Hope Floyd</b>		14. MOTHER'S MAIDEN NAME <b>Louise Glaeser</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17 INFORMANT <b>Rosewood Records, Owings Mills, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia bilateral</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>and terminal aspiration</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myotonic dystrophy</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (X) (this hospital) attended the deceased from <b>10-2</b> , 19 <b>39</b> , to <b>5-20</b> , 19 <b>66</b> that (X) (we) lost the deceased alive on <b>5-20</b> , 19 <b>66</b> , and that death occurred on <b>8:10 A.M.</b> from causes on the date stated above.			
22a. SIGNATURE <b>W. F. Eline</b> M.D.		22b. DATE SIGNED <b>5/20/66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/24/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Owings Mills, Md.</b>
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b> ADDRESS <b>Reisterstown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 23 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



FOR STATE HEALTH DEPT

06511

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06506

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>Baltimore</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FT. HOWARD HOSPITAL</b>				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1516 E. Biddle Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>FRANCIS FORTUNE</b>				4 DATE OF DEATH Month Day Year <b>5 17 1966</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH <b>7-7-40</b>	
9 AGE (In years last birthday) <b>25</b> yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARTENDER</b>		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12 CITIZEN OF WHAT COUNTRY?				13 FATHER'S NAME <b>ISAAC TRUSTY</b>			
14 MOTHER'S MAIDEN NAME <b>Cleo FORTUNE</b>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES</b>			
16 SOC. A. SECURITY NO. <b>220-327188</b>				17 INFORMANT <b>Cleo JACKSON</b> Address <b>1516 E. Biddle St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatty metamorphosis of liver</b> <b>5710</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Rudiger Brieteneker, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
22. DATE SIGNED <b>5-18-66</b>							
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>5/23/66</b>		23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d LOCATION (City or town) (County) (State) <b>5501 Frederick Ave. Baltimore</b>	
24. FUNERAL DIRECTOR <b>Joseph C. Lofgren</b>				25a REC'D BY REGISTRAR <b>MAY 19 1966</b>			
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06512						06507					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <i>Baltimore</i>			MARYLAND			a. STATE <i>Maryland</i>			b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			03-1		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greater Baltimore Medical Center</i>						d. STREET ADDRESS <i>4222 Lynhurst Rd 21222</i>					
3. NAME OF DECEASED (Type or print)			First <i>Mary</i>			Middle <i>—</i>			Last <i>Fox</i>		
4. DATE DEATH			Month <i>May</i>			Day <i>21</i>			Year <i>1966</i>		
5. SEX <i>Female</i>			6. COLOR OR RACE <i>White</i>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH <i>8/02/1905</i>		
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE (In years last birthday) <i>60</i> yrs.			IF UNDER 1 YEAR Months <i>—</i>			IF UNDER 24 HRS. Days <i>—</i> Hours <i>—</i> Min. <i>—</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Italy</i>			12. CITIZEN OF WHAT COUNTRY? <i>Italy</i>		
13. FATHER'S NAME <i>Rosario Papa</i>						14. MOTHER'S MAIDEN NAME <i>Rose Cimino</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>NA</i>			17. INFORMANT <i>PATIENTS CHART</i>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetic Nephropathy (Chronic Renal Failure)</i> DUE TO (c) <i>Diabetes Mellitus</i>									INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>5-19</i> , 19 <i>66</i> , to <i>5-21</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5-20</i> 19 <i>66</i> , and that death occurred at <i>3:40</i> AM, from the causes and on the date stated above.											
22a. SIGNATURE <i>Mercedes C. Alcantara</i>						ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <i>MERCEDES C. ALCANTARA</i>						22d. ADDRESS <i>GBMC</i>			22b. DATE SIGNED <i>5-21-66</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>5/24/66</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>		
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>						25a. REC'D BY REGISTRAR <i>MAY 24 1966</i>			25b. REGISTRAR'S SIGNATURE <i>gcharles Judge</i>		

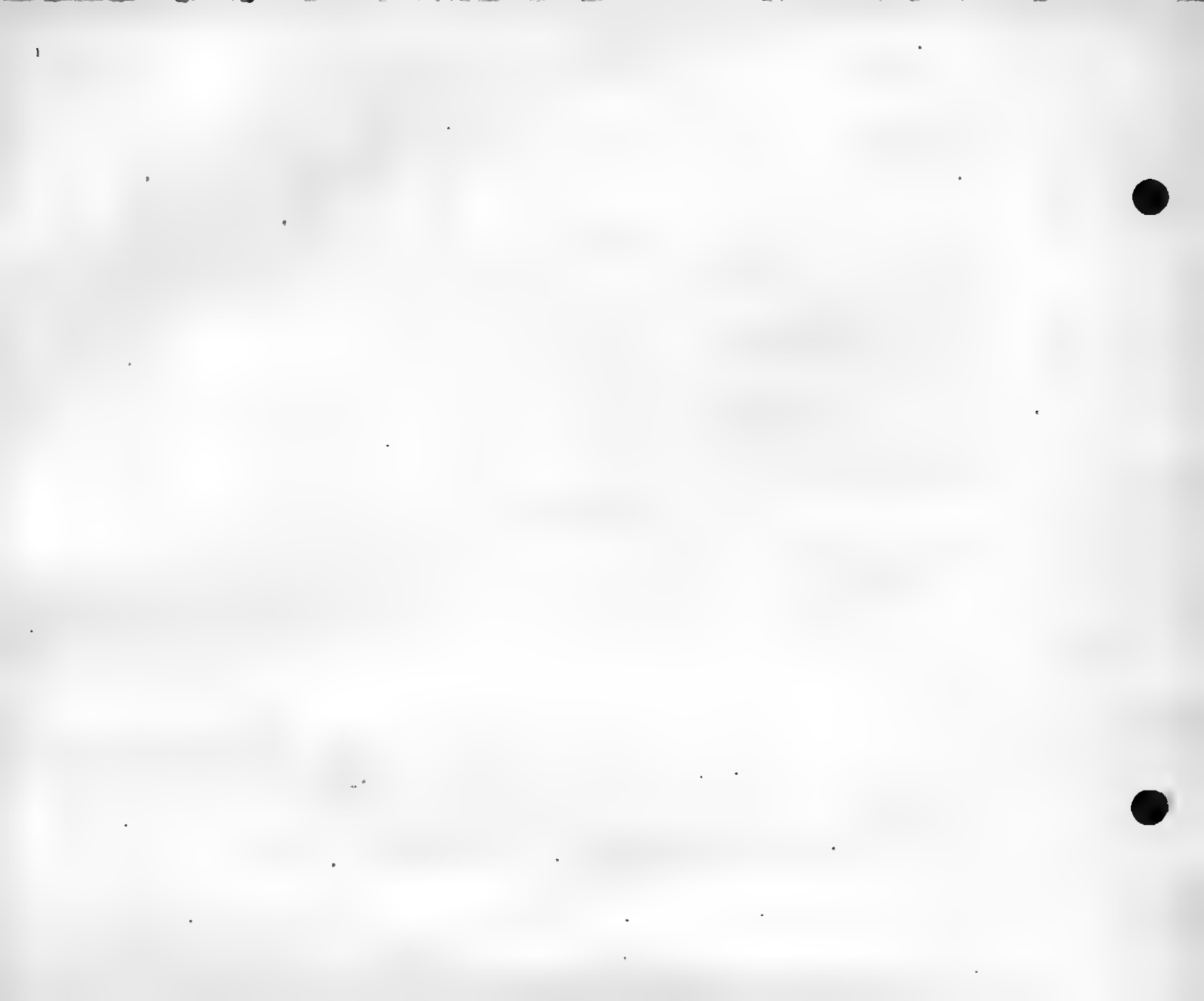




VR A15 (4)  
20M 1/65

## MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>CERTIFICATE OF DEATH</b>											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>Maryland</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b> d. STREET ADDRESS <b>9521 Fuller Ave. 21236</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Wilford</b> Middle <b>Fuller</b> Last <b>Fuller</b>				4. DATE OF DEATH Month <b>May</b> Day <b>12</b> , 19 Year <b>66</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 26, 1894</b>		9. AGE (In years last birthday) <b>71 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self employed</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Well digger</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Wilford Dent Fuller</b>				14. MOTHER'S MAIDEN NAME <b>Rose Unknown</b> <b>Box 174 Address Md.</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr Thomas Trimble Dance Mill Road Phoenix</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> (b) <b>diabetic acidosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.                      19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 11, 1966</b> to <b>May 12, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 12, 1966</b> , and that death occurred at <b>7:50 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) <b>Nelson S. de la Paz, M.D.</b>								ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>May 12, 1966</b> 22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-14-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hiss Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Co. Md.</b>					
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road</b>						25a. REC'D BY REGISTRAR <b>MAY 16 1966</b>		25b. REGISTRAR'S SIGNATURE 			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06514

06509

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>13 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Aged Women's + Aged Men's Home</u>				d. STREET ADDRESS <u>109 N. Athol St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lydia</u> Middle <u>Bella</u> Last <u>Gambrill</u>				4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 29, 1878</u> yrs.	
9. AGE (If years lost to (day) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hugh Fagen</u>				14. MOTHER'S MAIDEN NAME <u>EMMA HANSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-077549</u>			
17. INFORMANT <u>Daisy E. Hammett</u> Address <u>615 Chestnut Ave</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>4/21</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>2-24-1963</u> to <u>5-20-1966</u> , that (I) (we) last saw the deceased alive on <u>5-20-1966</u> , and that death occurred at <u>1030</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Newland Edward Day</u>				22b. DATE SIGNED <u>May 21, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Newland Edward Day</u>				22d. ADDRESS <u>4-E 33rd St Baltimore 18 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 23, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		23d. LOCATION (City, town, or county) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Corb. Brooks Towson</u> ADDRESS <u>1050 York Rd Towson Md</u>				25a. REC'D BY REGISTRAR <u>MAY 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

(M)

(7)

of



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06515

06510

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - ROCKDALE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WOODMANN</u>			
c. LENGTH OF STAY IN 1b <u>18 MONTHS</u>				d. STREET ADDRESS <u>2000 HILLCREST RD.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8409 MERRYMOUNT DRIVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>SOPHIE</u> Last <u>GAWEL</u>				4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1966</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 2, 1892</u>	
9. AGE (in years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Hungary</u>							
13. FATHER'S NAME <u>—</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-10-9283B</u>			
17. INFORMANT <u>DAUGHTER</u> Address <u>MRS CRAWFORD 8409 MERRYMOUNT DRIVE</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 4201 DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>15 YEARS</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>5/30</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> , 19 <u>50</u> , to <u>5/1</u> , 19 <u>66</u> , that (I) <del>was</del> last saw the deceased alive on <u>5/30</u> , 19 <u>66</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edwin L. Pierpont</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>				22d. ADDRESS <u>8204 LIBERTY RD - BALTO., MD. 21207</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/4/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>		23d. LOCATION (City, town or county) (State) <u>Balto., Md. County</u>	
24. FUNERAL DIRECTOR <u>J. T. Stansbury</u> ADDRESS <u>6411 Windsor Mill Rd.</u>				25a. REC'D BY REGISTRAR <u>MAY 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

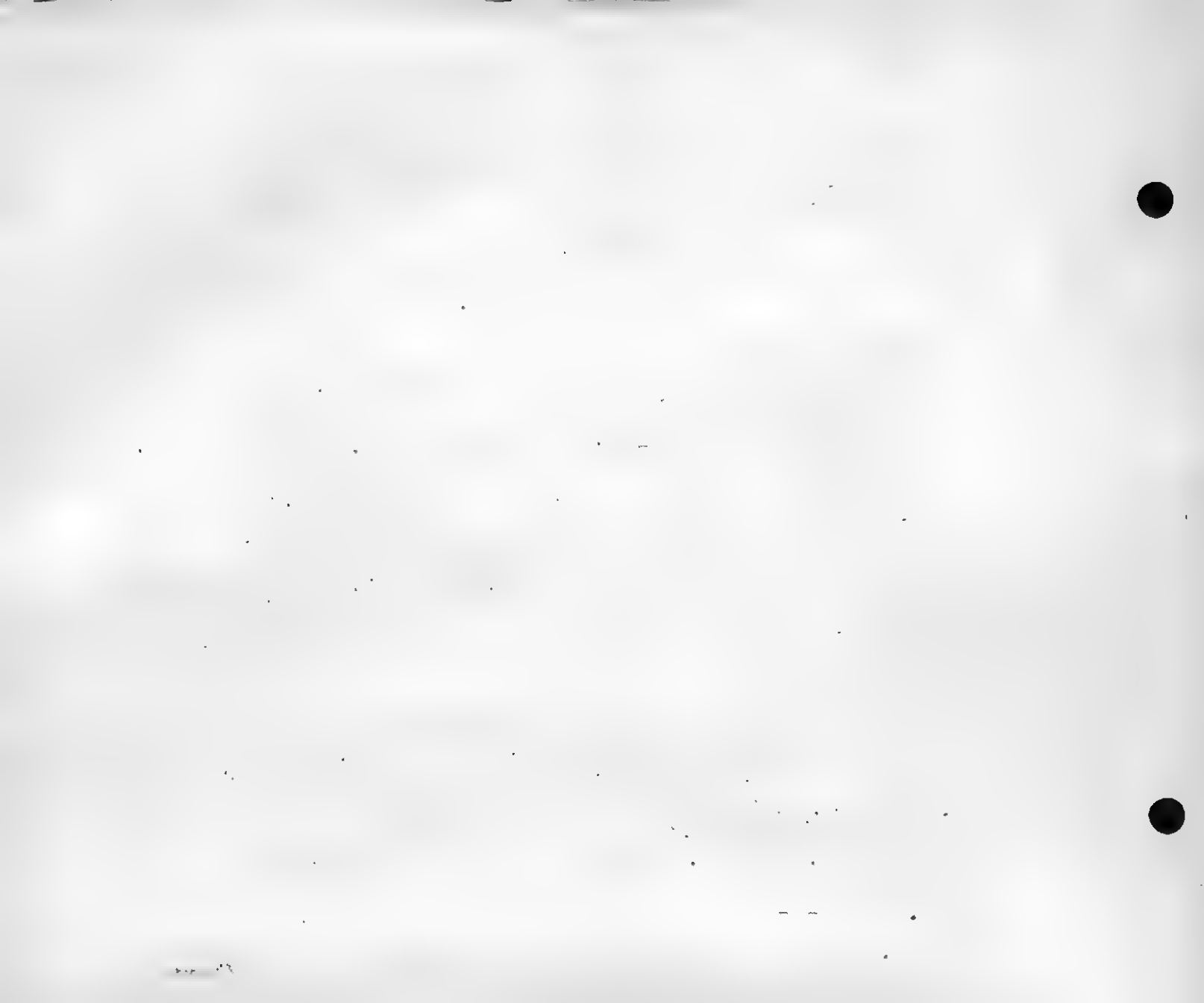


TO SURVIVAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Parkville</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Parkville (rural Baltimore)</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2452 Ellis Road</b>					d. STREET ADDRESS <b>2452 Ellis Road</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHRISTINE</b> Middle <b>CATHERINE</b> Last <b>GENSLER</b>					4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1966</b>						
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1882</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>1</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Thomas Hickey</b>					14. MOTHER'S MAIDEN NAME <b>Margaret Glenn</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>272-10-6594</b>		17. INFORMANT <b>Mrs. Thomas J. Finucan</b> Address <b>2452 Ellis Road, Balto.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> X <b>enlarged heart - gradual failure</b> DUE TO <b>Essential Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3) Diabetes mellitus 4) Coronary atherosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1955</b> to <b>May 5, 1966</b> that (I) (we) last saw the deceased alive on <b>May 3, 1966</b> and that death occurred at <b>2:07 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Donald W. Mintzer</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/6/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Dr. Donald W. Mintzer</b>					22d. ADDRESS <b>3009 Evergreen Ave., Balto., Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>			23b. DATE THEREOF <b>5-9-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. -- 5305 Harford Rd, Balto.</b>					25a. REC'D BY REGISTRAR <b>MAY 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John A. Judge</b>				





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06517

06512

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON - 4</b> c. LENGTH OF STAY IN 1b <b>Phoenix</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dulaney Valley Road &amp; Fox Chapel Road</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phoenix</b> d. STREET ADDRESS <b>4 Glenn Brook Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GARRY L. GERWIG</b> SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female 6 COLOR OR RACE <b>White</b> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4 DATE OF DEATH Month Day Year <b>5 8 1966</b> 8 DATE OF BIRTH <b>8-10-44</b> 9 AGE (In years last birthday) yrs <b>21</b> IF UNDER 1 YEAR Months Days Hours Min <b>21</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Western Electric Eng. Dept.</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Western Electric Eng. Dept.</b>		11 BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b> 12 CITIZENSHIP OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Charles R. Gerwig</b>		14. MOTHER'S MAIDEN NAME <b>Marjorie L. Caleman</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes, Navy</b>		16. SOCIAL SECURITY NO <b>Charles R. Gerwig, Phoenix, Md.</b>	
17 INFORMANT <b>Charles R. Gerwig, Phoenix, Md.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing injuries of the neck and right shoulder</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>shoulder</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Passenger in auto making left turn from Dulaney Valley Rd. onto Fox Chapel Road</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11:40</b> <b>5 8 19 66</b> p.m.		20d. INJURY OCCURRED Wh. a <input type="checkbox"/> Nat. While <input checked="" type="checkbox"/> of work 20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) <b>Road</b> 20f. (City or town) (County) (State) <b>Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>RUSSELL S. FISHER, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>5-9-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-11-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION (City or Town) (County) (State) <b>Timonium, Md.</b>	
24. FUNERAL DIRECTOR <b>Will. Cook-Brooks Towson, Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 13 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



CERTIFICATE OF DEATH

Reg. Dist. No. 06513

06513

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armacost Nursing Home</b>				d. STREET ADDRESS <b>2812 Overland Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Meta L. Gill</b> First Middle Last				4. DATE OF DEATH <b>May 25 1966</b> Month Day Year			
5 SEX <b>F</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1882</b>		9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Late-John Herrmann</b>				14. MOTHER'S MAIDEN NAME <b>Late-Nannie Eliza Lamb</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		INFORMANT Address <b>Edna Herrmann 2812 Overland Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain aneurysm</b> <b>4200</b> DUE TO <b>Cerebral sclerosis heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>yes.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1940</b> 19 to <b>5/25/66</b> 19, that I last saw the deceased alive on <b>5/24/66</b> 19, and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4331 Harpford Rd</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Walter F. B.</b> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-28-66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter F. B. - 4101 Edmondson Ave.</b> ADDRESS				24a. REC'D BY REGISTRAR DATE <b>MAY 31 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



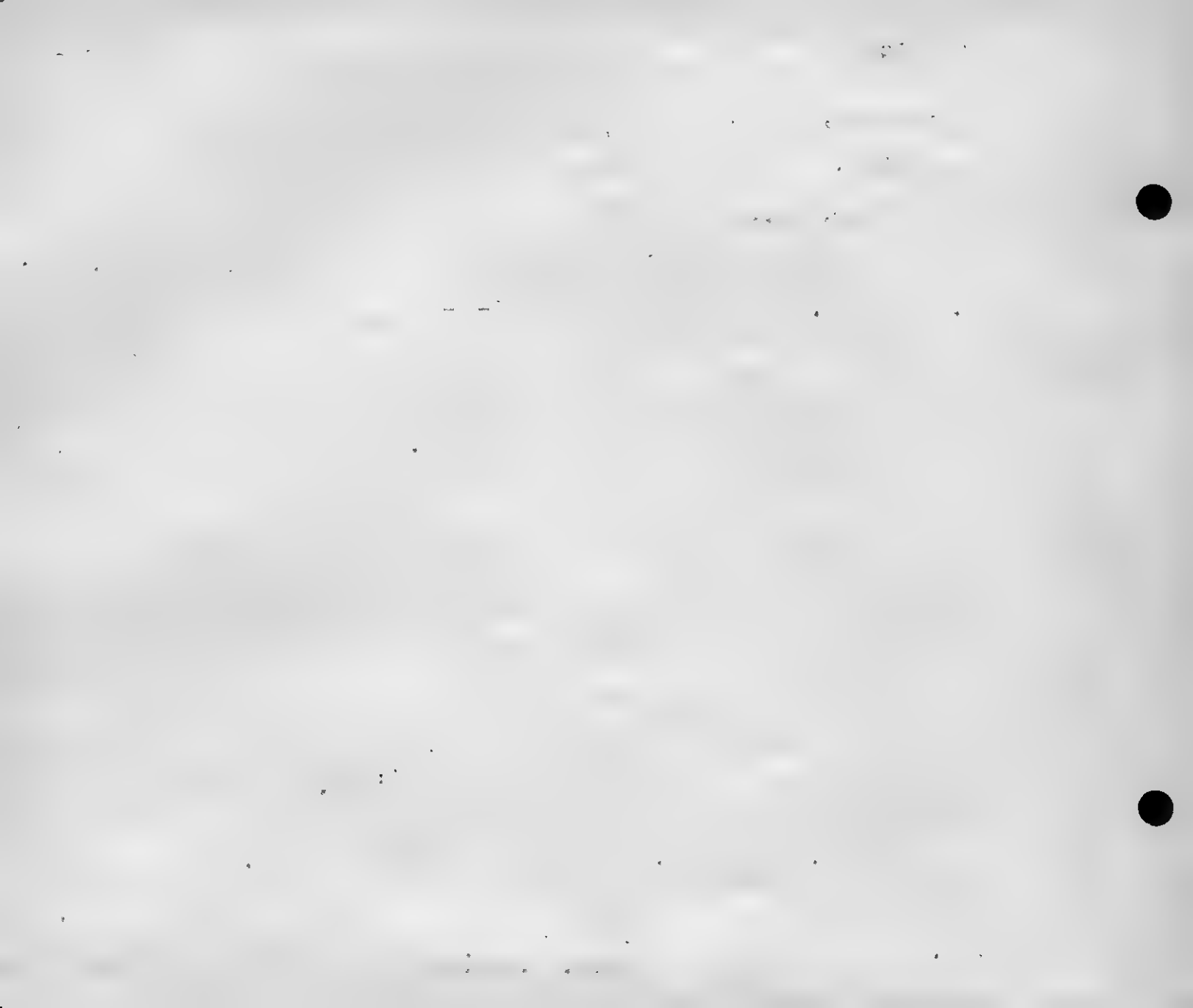
CERTIFICATE OF DEATH

06519

06514

1. PLACE OF DEATH a. COUNTY <b>Baltimore, County,</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>College Manor, Inc.,</b>		d. STREET ADDRESS <b>3409 Greenway</b>	
3. NAME OF DECEASED (Type or print) <b>Norah Purcell Gittings</b>		4. DATE OF DEATH <b>May 19th 1966</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-13-1874</b>
9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR: Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gervaise Purcell</b>		14. MOTHER'S MAIDEN NAME <b>Helen Hunt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-2642</b>	
17. INFORMANT <b>Thomas E. Rosser, Title Bldg. Balto. 2,</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4500</b> DUE TO <b>Cholesterol</b> Conditions, if any, which gave rise to immediate cause (b) <b>4500</b> DUE TO <b>Cholesterol</b> (a), stating the underlying cause last. (c) <b>4500</b> DUE TO <b>Cholesterol</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>May 18, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 18, 1966</b> , and that death occurred at <b>3:55 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. William G. Helfrich</b>		22b. DATE SIGNED <b>May 18, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. William G. Helfrich</b>		22d. ADDRESS <b>5006 Roland Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/23/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>4905 York Rd. Balto. 12, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>		DATE <b>MAY 23 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be removed from the certificate and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Items 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100											
1. PLACE OF DEATH a. COUNTY <b>Baltimore,</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>2808 Violet Ave</b> COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FALLO</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>30-4</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Dulaney-Towson Nursing Home, 111 West Rd., Towson, #, Md.</b>						e. STREET ADDRESS <b>2808 VIOLET AVE</b>					
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Goldstein</b> Last <b>Goldstein</b>						4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1885</b> <b>Nov. 3, 1885</b>		9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brass factory</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Abraham</b>						14. MOTHER'S MAIDEN NAME <b>Goldie Baranefsky</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>216-07-2185</b>		17. INFORMANT <b>SON</b>		Address <b>2707 W. GARRISON AVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>CARCINOMA RT. LUNG.</b> DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>1 YR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 15</b> , 19 <b>65</b> to <b>MAY 7</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>MAY 7</b> 19 <b>66</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Samuel I. O'Mansky</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>MAY 7, 66</b>			
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL I. O'MANSKY</b>						22d. ADDRESS <b>PS 23 LOCH RAVEN BLVD 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 19 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT CARMEL</b>			23d. LOCATION (City, town or county) (State) <b>BALTO. MD</b>				
24. FUNERAL DIRECTOR <b>SYLVAN S. LEWIS SON - 3319 OLYMPIA AVE</b>						25a. REC'D BY REGISTRAR <b>MAY 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			





FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06521

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06516

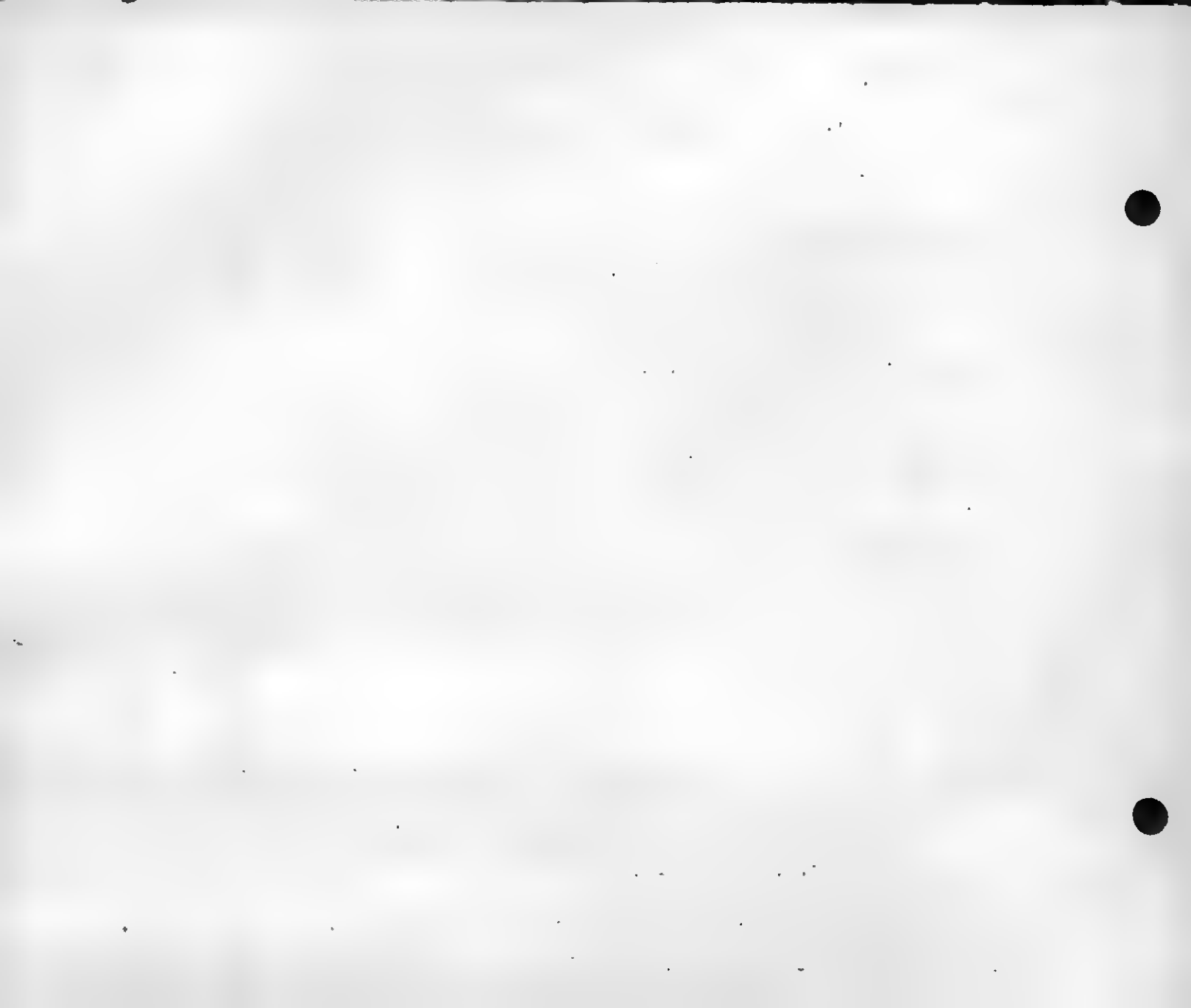
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>12</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>		d. STREET ADDRESS <b>6507 HARFORD RD</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>CHRIST</b> Last <b>GORDON</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-28-09</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>	9. AGE (In years last birthday) <b>57</b> yrs
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Buel C. Gordon</b>		14. MOTHER'S MAIDEN NAME <b>Florence Rutledge</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>215-01-3082</b>	
17. INFORMANT <b>Thelma Gordon</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>42-1 ACUTE MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, & county) <b>Baltimore County</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/31/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>
24. FUNERAL DIRECTOR <b>John C. Miller Jr.</b>		25a. REC'D BY REGISTRAR <b>John C. Miller Jr.</b>	25b. REGISTRAR'S SIGNATURE <b>John C. Miller Jr.</b>

JUN 1 1966



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06522					06517				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>21234</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>21234</u>			c. LENGTH OF STAY IN ID		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6713 Collinsdale Road</u>					d. STREET ADDRESS <u>6713 Collinsdale Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THE REV. First</u> <u>JOSEPH ARISTIDES GRAZIANI</u>			4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>1966</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/26/1905</u>		9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chaplain-retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Castel Sant'Elia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Graziani</u>					14. MOTHER'S MAIDEN NAME <u>Ursula Cammillucci</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Army</u>			16. SOCIAL SECURITY NO. <u>212-33-8104</u>		17. INFORMANT <u>Rosina Cascio, above</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4301</u> <u>Coronary Thrombosis</u> DUE TO (b) <u>Generalized atherosclerosis and</u> DUE TO (c) <u>Diabetes Mellitus</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1963</u> , to <u>May, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 5, 1966</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>J. Palmisano</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/12/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. Joseph F. Palmisano</u>					22d. ADDRESS <u>6608 Loch Raven Blvd.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>5/13/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>					25a. REC'D BY REGISTRAR <u>MAY 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		



CERTIFICATE OF DEATH

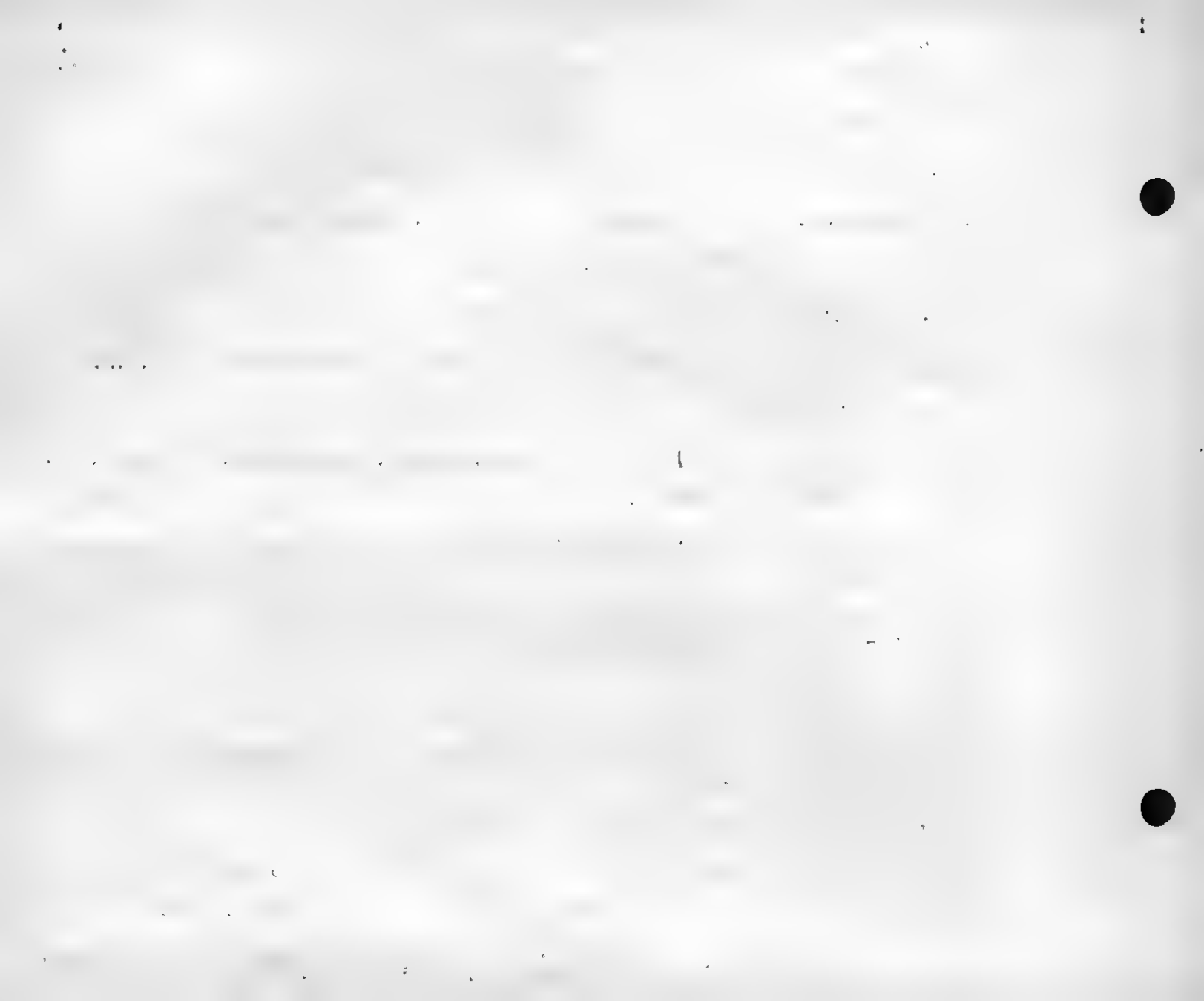
06523

06518

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>402 N. PULASKI STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>LEE</b> Last <b>GREGORY</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>11</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 3, 1919</b>
9. AGE (in years last birthday) <b>46</b> yis.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b> Hours <b>66</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CHEVROLET</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BULOCK, NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLARENCE GREGORY</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>233 12 24 88</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> DUE TO (b) <b>MYOCARDIAL HEMORRHAGE</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>Recent</b> <b>One day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Thrombo-Embolism Left Middle Cerebral Artery</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>5/8/66</b> , 19__, to <b>5/11/66</b> , 19__, that <b>(H)</b> (we) lost the deceased alive on <b>5/11/66</b> , 19__, and that death occurred at __ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Alicia O. Mendez-Ross</b>		22b. DATE SIGNED <b>5/11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALICIA O. MENDEZ-ROSS, M.D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5-16-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>Charles R. Law</b>		25a. REC'D BY REGISTRAR <b>Charles R. Law</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles R. Law</b>		25c. DATE <b>MAY 16 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06524

06519

1. PLACE OF DEATH  
a. COUNTY **Baltimore County** MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Essex**  
c. LENGTH OF STAY IN 1b **Life**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **12 Avenal Rd.**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE **Maryland**  
b. COUNTY **Baltimore**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Essex (21)**  
d. STREET ADDRESS **12 Avenal Road**

3. NAME OF DECEASED (Type or print) **Catherine E. Grim**  
4. DATE OF DEATH **5 24 1966**  
5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH **Oct. 25 1880** 9. AGE (In years last birthday) **85 yrs** IF UNDER 1 YEAR: Months **5** Days **24** Hours **19** Min. **66** IF UNDER 24 HRS.: Months **5** Days **24** Hours **19** Min. **66**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY **None** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13. FATHER'S NAME **George Huebschmann** 14. MOTHER'S MAIDEN NAME **Mary Bechman**

15. WAS DECLARED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO **213 05 2523** 17. INFORMANT **John R. Grim** Address **8212 Diamond Point Rd.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Acute Coronary Occlusion**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **Arteriosclerotic Heart Disease**  
DUE TO (c) **Congestive Heart Failure**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))  
**Congestive Heart Failure**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED **While at work** 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **factory, street, office bldg., etc.** 20f. (City or town) **Baltimore** (County) **Baltimore** (State) **Md.**

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Theo C. Patterson** CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) **THEO C. PATTERSON** ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☐

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **5/28/66** 22c. NAME OF CEMETERY OR CREMATORY **Holy Redeemer Cemetery** 22d. LOCATION (City, town, or country) **Baltimore, Maryland**

23. FUNERAL DIRECTOR **A. Christine Brudzinski** ADDRESS **1407 Eastern Ave.** 24a. REC'D BY REGISTRAR **MAY 27 1966** 24b. REGISTRAR'S SIGNATURE **Charles Judge**



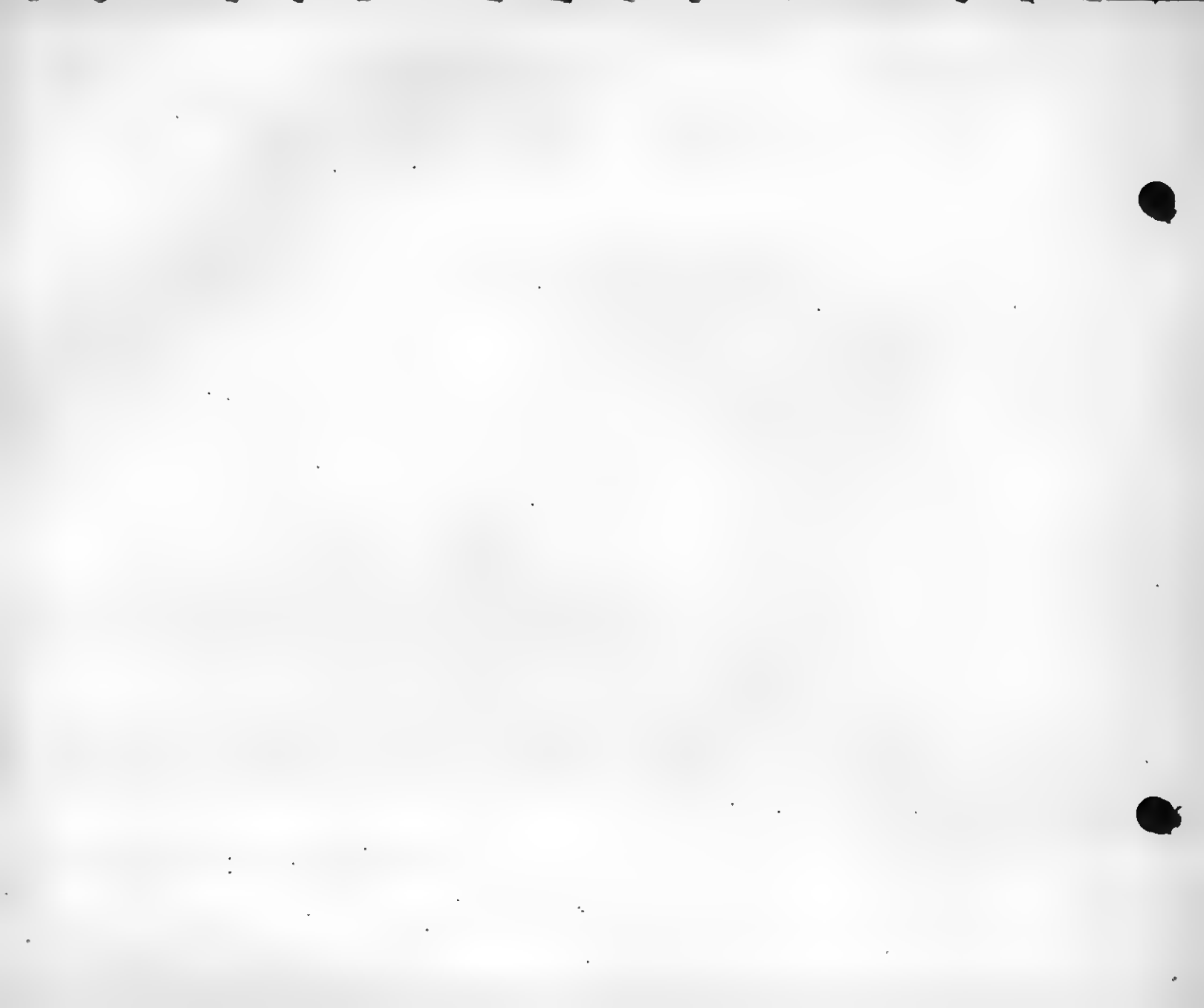


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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 9 31m 0377 6/6/66 mh 06525 06520											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>STEVENSON</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VILLA JULIE</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>STEVENSON</b> d. STREET ADDRESS <b>VALLEY ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>SISTER MARIE MICHAEL GRIMES</b> First Middle Last						4. DATE OF DEATH <b>MAY 29 1966</b> Month Day Year					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AVG. 2, 1884</b>		9. AGE (in years last birthday) <b>81</b> yrs.		10. FUNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RELIGIONIST</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>		11. BIRTHPLACE (County & State, or foreign country) <b>IRELAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JOHN GRIMES</b>						14. MOTHER'S MAIDEN NAME <b>CATHERINE FOX</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Dr. Mary Margaret - Villa Julie</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vas. Disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>May 29, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 29 1966</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Harold H. Burns</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5-30-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Harold H. Burns</b>						22d. ADDRESS <b>8106 Harford Rd. Balto 39-MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5-31-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Steuers MD.</b>					
24. FUNERAL DIRECTOR <b>John Covarrubias</b>						ADDRESS <b>H. Catonville Trd.</b>		25a. REC'D BY REGISTRAR <b>JUN 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06526					06521						
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			c. LENGTH OF STAY IN 1b <i>1913-66</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto. 7, Md.</i>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Balto. Co. General</i>					d. STREET ADDRESS <i>3709 N. Rogers Ave.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ALBERT W. GRIMMER</i>			First Middle Last		4. DATE OF DEATH <i>MAY 7 1966</i>		Month Day Year				
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-22-1904</i>		9. AGE (In years last birthday) <i>61</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Germany</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Karl Grimmer</i>					14. MOTHER'S MAIDEN NAME <i>Pauline Schuster</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRO-VASCULAR THROMBOSIS, MIDDLE CEREBRAL ARTERY</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>X</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>PARKINSONISM</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>5/6</i> , 19 <i>66</i> , to <i>5/7</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5/7</i> , 19 <i>66</i> , and that death occurred at <i>2:45</i> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <i>B. Alonso</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <i>5/7/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>B. ALONSO, M.D.</i>					22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <i>5-11-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Balto, Maryland</i>			
24. FUNERAL DIRECTOR <i>ELLsworth ARMACOST - 4600 Liberty Hgts</i>					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>				



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>06527</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>06522</span> </div> <div style="text-align: center;"> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Forest Haven Nursing Home</b>								d. STREET ADDRESS <b>5814 Gwynn Oak Ave. 15</b>			
3. NAME OF DECEASED (Type or print) First <b>Olive</b> Middle <b>V.</b> Last <b>Griswold</b>				4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>1966</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 7, 1890</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR: Months <b>05</b> Days <b>1</b> IF UNDER 24 HRS: Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Lumpkin Company</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles H. Griswold</b>						14. MOTHER'S MAIDEN NAME <b>Letitia Moore</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Mr. A. G. Griswold</b> Address <b>4404 Fernhill Ave.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vase Accident</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Hypertensive CVD</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1966</b> to <b>May 2, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 1, 1966</b> and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Dr. Thomas G. Cotton</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas G. Cotton</b>						22d. ADDRESS <b>1509 Liberty Hwy. Ellicott City, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/5/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Pikesville, Md.</b>					
24. FUNERAL DIRECTOR <b>Wm. J. Tichner Sons</b>						25a. REC'D BY REGISTRAR <b>Baltimore, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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1960

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VR AIS (4)  
20M 1/65

## CERTIFICATE OF DEATH

03528

06523

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b> ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN lb <b>6 yrs.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. STREET ADDRESS <b>Christie Road - Route #4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Royce</b>		First <b>Eugene</b>		Last <b>GROSS</b>		4. DATE OF DEATH Month <b>5</b> Day <b>17</b> Year <b>1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/13/23</b>	
9. AGE (in years last birthday) <b>42 yrs.</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>17</b>		11. IF UNDER 24 HRS. Hours <b>19</b> Min. <b>66</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>no</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>no</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Oliver Wilson Gross</b>				14. MOTHER'S MAIDEN NAME <b>WENTLING, Edith E.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Rosewood records, Owings Mills, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diptheria pneumonia, bacterial</b> <b>Aspiration type</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Bronchektasia, severe, bilateral</b> (c) <b>Spastic Quadriplegia (Birth)</b>		19. INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>5-15</b> , 19 <b>66</b> , to <b>5-17</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-17-66</b> 19 <b>66</b> , and that death occurred at <b>1:18</b> AM, from the causes and on the date stated above.		22a. SIGNATURE <b>Harvey G. Bunker</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED <b>5-18-66</b>		22f. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/21/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Herman Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland 21502</b>		25a. REC'D BY REGISTRAR <b>MAY 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE - 6</u> c. LENGTH OF STAY IN 1b <u>151X</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5706 EAST AVENUE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE - 6</u> d. STREET ADDRESS <u>5706 EAST AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARETTA</u> First <u>HAMEL</u> Middle <u>HAMEL</u> Last		4. DATE OF DEATH <u>MAY 15</u> Month <u>15</u> Day <u>1966</u> Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-1894</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN PETER HOFMANN</u>		14. MOTHER'S MAIDEN NAME <u>MARGARETTA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. DORIS WILSON</u>		Address <u>5706 EAST AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> (2) 151X DUE TO <u>Carcinomatosis</u> (1) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>1 yr</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <u>G.M. Baumgardner</u> M.D.		22b. DATE SIGNED <u>6/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>G.M. Baumgardner</u>		22d. ADDRESS <u>Baltimore 6 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-18-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SCHWARTZ'S CEM.</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE MD.</u>	
24. FUNERAL DIRECTOR <u>HOFFMANN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>Charles J. Jago</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JUN 6 1966</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06530

06524

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Roseado</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7905 Pulaski Highway</u>		d. STREET ADDRESS <u>7905 Pulaski Highway</u>	
3. NAME OF DECEASED (Type or print) <u>TROY D. HAMPTON SR.</u>		4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 30, 1892</u>
9 AGE (In years last birthday) <u>73</u> yrs		10 UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11 UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motel owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motel</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>FRANK HAMPTON</u>		14. MOTHER'S MAIDEN NAME <u>LAURA HAYES</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>215-03-7806</u>	
17. INFORMANT <u>Martha A. Hampton</u>		Address <u>7905 Pulaski Hgy.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE LUNG.</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFIKANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/11</u> , 19 <u>66</u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>5/11</u> , 19 <u>66</u> , and that death occurred at <u>1:30 P.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>Lawrence J. Pazourek</u>		22b. DATE SIGNED <u>5/11/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>LAWRENCE J. PAZOUREK</u>		22d. ADDRESS <u>5019 PHILADELPHIA RD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>	23b. DATE THEREOF <u>May 14, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Worshiping Mausoleum</u>	23d. LOCATION (City or Town) (County) (State) <u>Woodlawn, Maryland</u>
24 FUNERAL DIRECTOR <u>Philip E. Couch</u>		25a RECEIVED BY REGISTRAR <u>MAY 10 1966</u>	
ADDRESS <u>1211 Chesaco Ave.</u>		25b REGISTRAR'S SIGNATURE <u>James Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



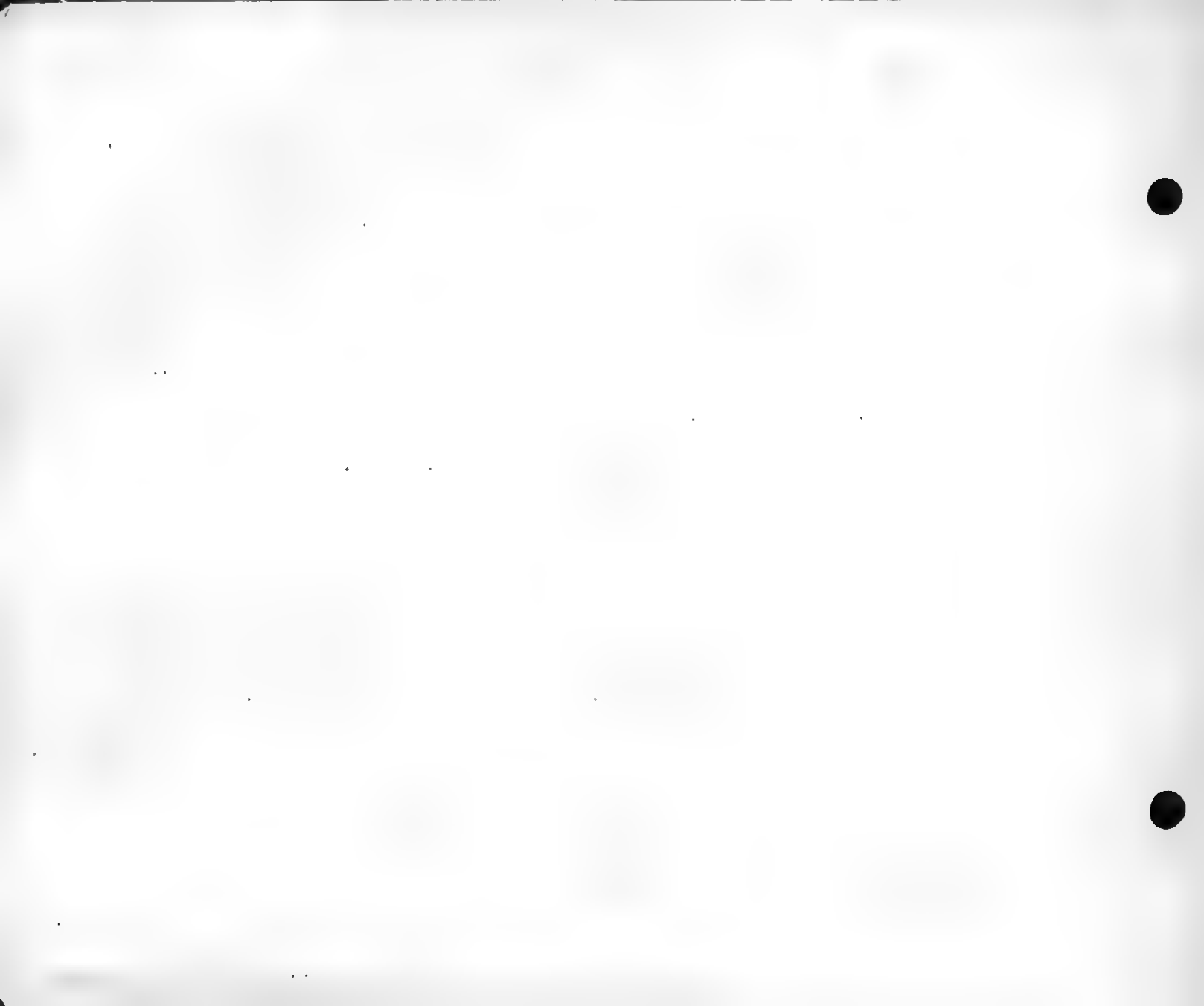
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>Phoeninx</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Dulaney Valley Road</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Phoeninx</b> d. STREET ADDRESS <b>6 Glenn Brook Drive</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>RAYMOND L. HARDESTY</b>		4. DATE OF DEATH Month Day Year <b>5 8 19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3-18-45</b>
9 AGE (In years last birthday) <b>21 yrs</b>		10 IF UNDER 1 YEAR Months Days Hours Min. <b>21 0 0 0</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Raymond L. Hardesty, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Moulton</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>218-44-5554</b>	
17. INFORMANT <b>Barton S. Nagle, Same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing injuries of abdomen with hemoperitoneum</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Passenger in auto making left turn from Dulaney Valley Rd. into Fox Chapel</b>			
19 PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20	
20a EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>auto auto</b>	
20c TIME OF INJURY Month, Day, Year <b>1:40 pm 5 8 19 66</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Road</b>		20f (City or town) (County) (State) <b>Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>RUSSELL S. FISHER, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22 DATE SIGNED <b>5-9-66</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)		23a BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>	
23b DATE THEREOF <b>May 11, 1966</b>		23c NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>	
23d LOCAT ON (City or Town) (County) (State) <b>Cockeysville, Balto., Md.</b>		23e REC'D BY REGISTRAR <b>MAY 13 1966</b>	
23f REGISTRAR'S SIGNATURE <b>Charles Judge</b>		24 FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road, Towson 4, Maryland</b>	



CERTIFICATE OF DEATH

C6532

06526

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY IN TB <u>3 1/2 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md. Masonic Home</u>		d. STREET ADDRESS <u>North Market St.</u>	
3. NAME OF DECEASED (Type or print) <u>May Pearl Harrington</u>		4. DATE OF DEATH <u>May 13 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1888</u>
9. AGE (In years lost birthday) <u>78 yrs</u>		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>13</u> IF UNDER 24 HRS: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Frederick, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lewis E. Burek</u>		14. MOTHER'S MAIDEN NAME <u>Catherine King</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-10-1875</u>	
17. INFORMANT <u>Records of Md. Masonic Home - Cockeysville</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1. Generalized Carcinomatosis</u> <u>170X</u> DUE TO (b) <u>2. Carcinoma of uterus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (c) <u>3. Carcinoma of breast</u> <u>postmenopausal heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 15, 1953</u> , to <u>May 12, 1966</u> that (I) (we) last saw the deceased alive on <u>May 12, 1966</u> , and that death occurred at <u>8:15 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Jamshid Hamed</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMSHID HAMED</u>		22d. ADDRESS <u>1227 DULANEY VALLEY ROAD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-16-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>FREDERICK MARYLAND</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Tolson</u>		25a. REC'D BY REGISTRAR <u>1050 YORK ROAD</u> 25b. REGISTRAR'S SIGNATURE <u>JAMES JUDGE</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





## CERTIFICATE OF DEATH

06533

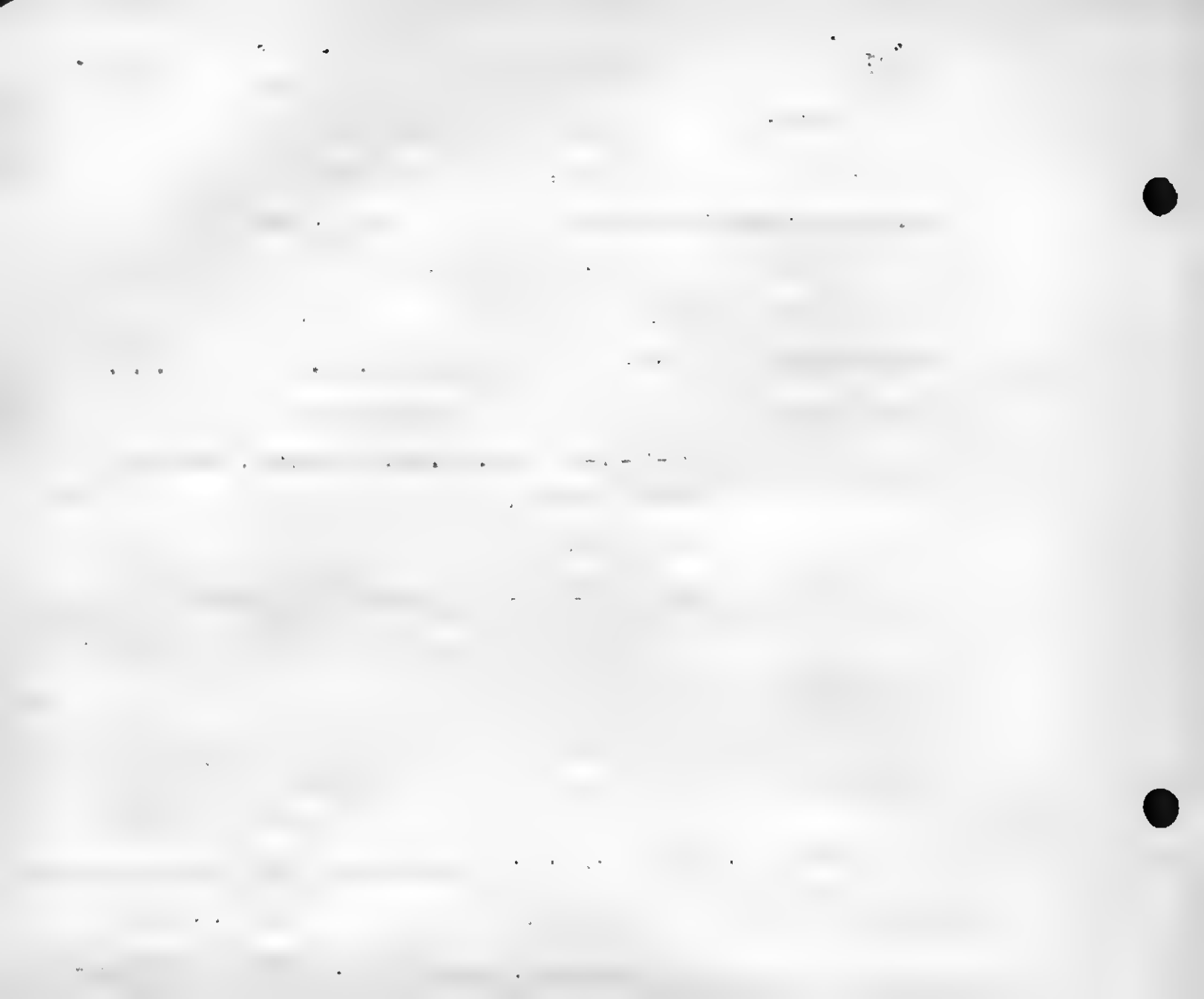
06527

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN TB <b>13 Hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>2617 Beryl Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIE J. HARRIS</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>4</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/16/95</b>
9. AGE (In years last birthday) yrs <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Farmville, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Harris</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Woodsen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>217-10-42-07</b>	
17. INFORMANT <b>Clin. Rec. VAH, Fort Howard, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT, BILATERAL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>RENAL FAILURE</b> (c) <b>GLOMERULONEPHRITIS AND MULTIPLE CYSTS KIDNEY</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5/3/66 11:15AM</b> to <b>5/4/66</b> , 19__, that (I) (we) lost saw the deceased alive on <b>5/4/66</b> , 19__, and that death occurred at <b>12:55AM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence F. Awalt, Jr.</i>		22b. DATE SIGNED <b>5/4/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE F. AWALT, JR., M. D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5/9/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR		25. REC'D BY REGISTRAR <b>ELICKSON FUNERAL HOME, MAY 5 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or a completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

06534

06528

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>26yrlmth13dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head, Maryland</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>	
e. STREET ADDRESS <b>none</b>		f. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>C.</b> Last <b>Hartman</b>		4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9 1912</b>
9. AGE (In years last birthday) <b>53</b> yrs		10. IF UNDER 1 YEAR Months <b>13</b> Days <b>13</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>sheet iron worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Evan Hartman</b>		14. MOTHER'S MAIDEN NAME <b>Cora B. Arthur</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>unknown</b>	
17. INFORMANT <b>Records : SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure with pulmonary edema</b> 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebrovascular accident</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <b>March 27 1960</b> , to <b>May 13 1966</b> , that (b) (we) last saw the deceased alive on <b>May 13 1966</b> , and that death occurred at <b>8:45</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b>		22b. DATE SIGNED <b>5-13-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5/16/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT COMFORT</b>	23d. LOCATION (City or Town) (County) (State) <b>FAIRFAX CO. VA</b>
24. FUNERAL DIRECTOR <b>Walter T. Holt</b>		25. READ BY REGISTRAR <b>MAY 17 1966</b>	
ADDRESS <b>CUNNINGHAM FUNERAL HOME INC. ALEX. VA</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MED. CENTRE</b>		d. STREET ADDRESS <b>JARRETSVILLE PIKE (2113)</b>	
3. NAME OF DECEASED (Type or print) First <b>AILEEN</b> Middle <b>S.</b> Last <b>HECKER</b>		4. DATE OF DEATH Month <b>(18)</b> Day <b>19</b> Year <b>66</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>CAU.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-13-01</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (Count. & State, or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES E. RUHL</b>		14. MOTHER'S MAIDEN NAME <b>SARAH E. RUHL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-42-6760</b>	
17. INFORMANT <b>MRS. STEWART S. WHITE</b>		Address <b>(SAME)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b> DUE TO (c) <b>ACUTE MYOCARDIAL INFARCTION</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ACUTE MYOCARDIAL INFARCTION</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 13<sup>th</sup></b> , 19 <b>66</b> , to <b>MAY 18<sup>th</sup></b> , 19 <b>66</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>MAY 18<sup>th</sup></b> , 19 <b>66</b> , and that death occurred at <b>6:55AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Thaddeus Prout</i>		22b. DATE SIGNED <b>5/18/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. THADDEUS PROUT</b>		22d. ADDRESS <b>3808 FENCHURCH RD. BALTIMORE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/21/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Pl.</b>		23d. LOCATION (City, town or county) (State) <b>Parkville, Balto. Co. Md.</b>	
24. FUNERAL DIRECTOR <i>Henry W. Jenkins</i>		25a. REC'D BY REGISTRAR <b>MAY 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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20M 5-63

06530

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 21208</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Nelson Rd.</u>		d. STREET ADDRESS <u>Nelson Road</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Rachel Cecelia Hemelt</u>		<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>19</u> Year <u>1966</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb 17, 1888</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Cockeysville, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Frederick A. Warrenner</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Elizabeth Barrett</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>215-34-1200</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis C.V.D.</u> 4-2-21 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour <u>—</u> a.m. <u>—</u> p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May 14, 1966</u> , <b>1966</b> , <b>to</b> <u>May 19, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>May 19, 1966</u> , <b>and that death occurred at</b> <u>10:30 A.M.</u> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Charles H. Williams</u>		<b>22b. DATE SIGNED</b> <u>May 19, 1966</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Charles H. Williams</u>		<b>22d. ADDRESS</b> <u>Pikesville 8, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>May 23, 1966</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Charles Cemetery</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Pikesville 8, Md.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Frank A. Small</u>		<b>25. REC'D BY REGISTRAR</b> <u>2 1966</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06537					06531						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>Baltimore</b>					a. STATE <b>Maryland</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					b. COUNTY						
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>					d. STREET ADDRESS <b>142 Westbury Rd. 21093</b>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
			<b>Harold Edward Hendrickson</b>			<b>May</b>			<b>19 66</b>		
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-16-21</b>		9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (give kind of work done during most of working life, even if retired) <b>Sales Supervisor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Campbell Sales Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Randall Hendrickson</b>						14. MOTHER'S MAIDEN NAME <b>Jessie VanAken</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>111-11-1111</b>		17. INFORMANT <b>Family Records</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolization with massive infarction.</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Recent posterior myocardial infarction.</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 8, 1966</b> to <b>May 19, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 19, 1966</b> , and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>D.R. Govinda Rao</b>										22b. DATE SIGNED <b>May 20, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>D.R. Govinda Rao, M.D.</b>				22d. ADDRESS <b>7620 York Rd. Baltimore, Md. 21204</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal/Burial May 25, 1966</b>				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Stone Ridge Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Stone Ridge, N.Y.</b>			
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>						25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

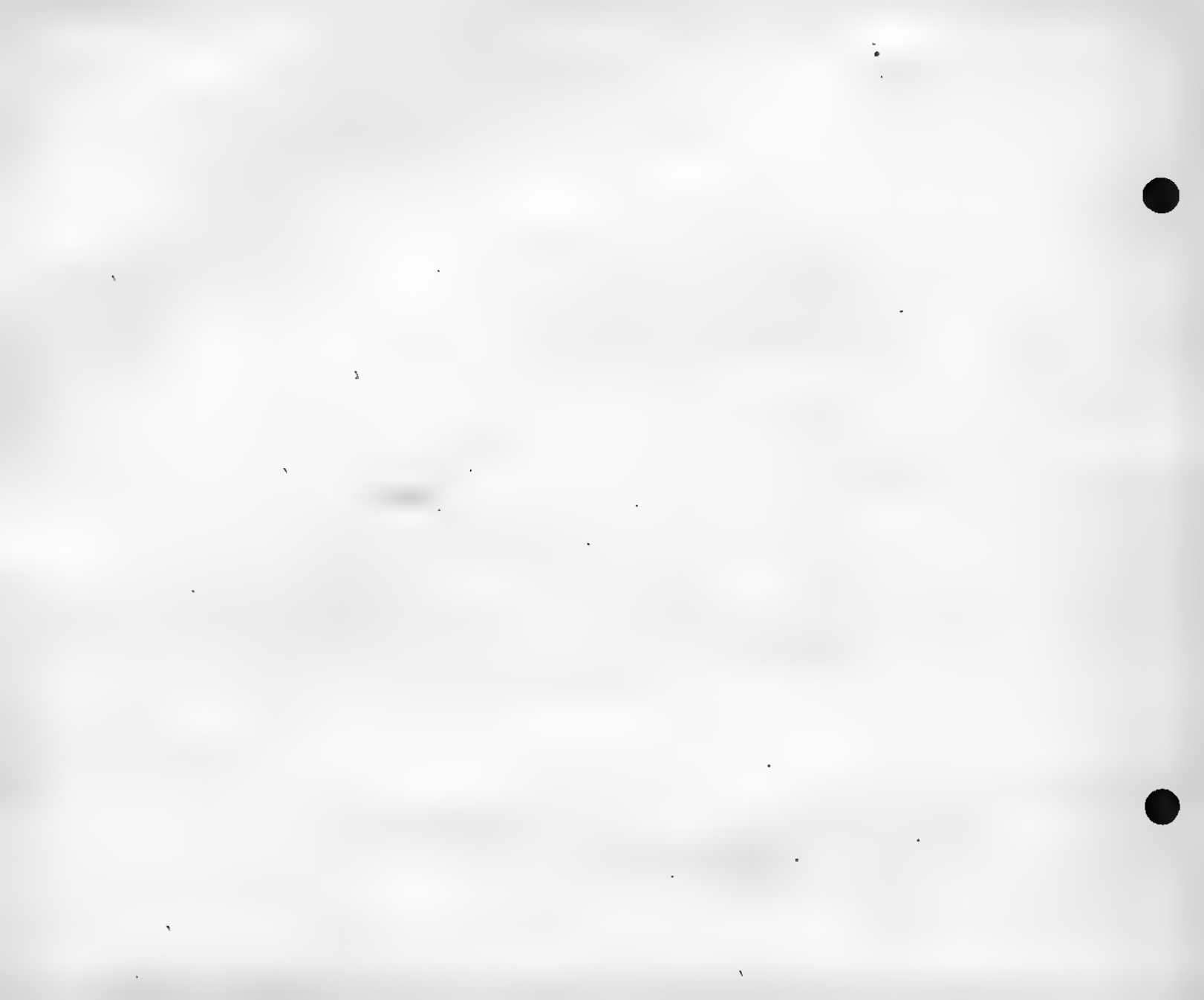
CERTIFICATE OF DEATH

06532

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> c. LENGTH OF STAY IN 1b <b>ARBUS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1113 CIRCLE DRIVE 21227</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE A. HERGET</b>		4. DATE OF DEATH Month Day Year <b>MAR 19 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-20-1883</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF-EMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	9. AGE (In years last birthday) <b>82</b> yrs
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND, BALTO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE HERGET</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE EICHORN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>MISS GLADYS HERGET, 1113 CIRCLE DRIVE</b>	
17. INFORMANT <b>MISS GLADYS HERGET, 1113 CIRCLE DRIVE</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Hypertensive cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b> <b>4 mo.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <b>Serology</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 1, 1966</b> to <b>May 19, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 11, 1966</b> , and that death occurred at <b>6P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>A. Bradley Daugharthy</b>		22b. DATE SIGNED <b>5-20-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. Bradley Daugharthy</b>		22d. ADDRESS <b>1264 FRANCIS AVENUE 21227</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5-21-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD, 4107 WILKENS AVE. #2</b>		25. REC'D BY REGISTRAR <b>MAY 23 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06533

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>36 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Res., Apt. # 5 Dundalk Apartments,.....</b>		d. STREET ADDRESS <b>37 Shipping Place 21222</b>	
3 NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>E.</b> Last <b>Herman</b>		4 DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>66</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 26- 1895</b>
9 AGE (In years last birthday) <b>70</b> yrs		10 IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>- -</b>	
11 BIRTHPLACE (State or foreign country) <b>New York</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Theophilus Borden</b>		14. MOTHER'S MAIDEN NAME <b>Lola Borden</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>No</b>	
17 INFORMANT <b>Husband, Mr. Paul Herman, # 2, a, b, c, d.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Occlusion (Coronary)</b> <b>4301</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ASHD</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year <b>10 15 AM 5/7/66</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f (City or town) (County) (State) <b>Dundalk Baltimore Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>May 9- 1966</b>	
ACTUAL SIGNATURE <b>Theodore C. Patterson</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Theodore C. Patterson, M.D. 105 Main St. Dundalk, Md. 21222</b>		DEPUTY MED. CAL. EXAM. NER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>May 11- 1966</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d LOCATION (City or Town) (County) (State) <b>Catonsville, Md. 21228</b>	
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>		25a REC'D BY REGISTRAR <b>MAY 10 1966</b>	
25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		Md.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Forest Haven Nursing Home				817 N. Port Street					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH	
RUDOLPH				HERMAN				May 6, 1966	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
male		white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4/10/1888		78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months Days Hours Min.	
Painter		Beth Steel		Czechoslovakia		U.A.S.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
unknown				unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
		217-20-3419		Henrietta Lhotsky, neice, above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO 4201 DISEASE - MYOCARDIAL INFARCTION									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 4/10, 1966, to 5/6, 1966, that (I) (we) last saw the deceased alive on 5/6, 1966, and that death occurred at 12:30 PM from the causes and on the date stated above.									
22a. SIGNATURE									
22b. DATE SIGNED 5/6/66									
22c. PHYSICIAN'S NAME (Type) Dr. John H. Shaw									
22d. ADDRESS 5800 Edmondson Ave. BALTIMORE, MD.									
22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF 5/9/66									
23c. NAME OF CEMETERY OR CREMATORY Bohemian National Cem									
23d. LOCATION (City, town or county) (State) Baltimore, Md.									
24. FUNERAL DIRECTOR Schumacher Funeral Home, Inc. 2601 E. Madison St.									
25a. REC'D BY REGISTRAR MAY 12 1966									
25b. REGISTRAR'S SIGNATURE Charles Judge									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
CERTIFICATE OF DEATH										
Reg. Dist. No. 66535										
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville, Md.</u>			c. LENGTH OF STAY IN 1b <u>3 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park, Md.</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines</u>					d. STREET ADDRESS <u>Doris Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ELSIE</u> Middle <u>ROSE</u> Last <u>HIEBLER</u>					4. DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>1-21-1911</u>		9. AGE (In years last birthday) <u>55</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York State</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Noah W. Akers</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Eleanor Krell</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>212-22-2231</u>		17. INFORMANT <u>Kenneth P. Hiebler, 2811 Oak Grove, 27</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Carcinoma</u> <u>114 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma 2 Intestines</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>3 yr.</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-17-1966</u> , to <u>5-11-1966</u> , that I last saw the deceased alive on <u>5-10-1966</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>William K. Gallagher Sr.</u> M.D. <u>6201 Frederick Ave.</u> <u>5-12-66</u> PHYSICIAN'S NAME (Type) <u>William K. Gallagher Sr.</u> <u>Baltimore, 21225</u> <u>Md.</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-14-66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park Cem.</u>			22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Flynn &amp; Fleming</u>					ADDRESS <u>1422 Light St. 30</u>		24a. REC'D BY REGISTRAR <u>MAY 16 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

Reg. Dist. No. **06536**

**06542**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>296 Bloomsbury Ave.</b>		d. STREET ADDRESS <b>296 Bloomsbury Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ABEL A. HOLLAND</b>		4. DATE OF DEATH Month Day Year <b>May 25 1966 19</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15, 1895</b>
9. AGE (In years lost birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Wright</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
INFORMANT <b>Robert R. Holland</b>		Address <b>1200 Edmondson</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>arteriosclerotic Cardio Vasc. Rend Disease</b>			
(b) <b>Diabetes Mellitus</b>			
(c) <b>Benign Hypertension</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 27, 1954</b> to <b>May 25, 1966</b> that I last saw the deceased alive on <b>May 24, 1966</b> and that death occurred at <b>3:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harry L. Knipp</b>		DATE SIGNED <b>5-25-66</b>	
PHYSICIAN'S NAME (Type) <b>HARRY L. KNIPP, M.D.</b>		ADDRESS (Street, city or town, state) <b>4116 Edmondson Ave. Baltimore 29 Md.</b>	
22a. BURIAL, CREMATION, or MOV. A. (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/28/66</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>(WITKIE) WITKIE</b>		ADDRESS <b>4101 Edmondson Ave.</b>	
24a. REC'D BY REGISTRAR <b>MAY 31 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove certificates. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
06543 CERTIFICATE OF DEATH 06537

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ashland (Cockeysville)</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ashland Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Cockeysville) Ashland</u> d. STREET ADDRESS <u>Ashland Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Stewart L.S. Hollingshead</u> First Middle Last		4. DATE OF DEATH <u>May 18, 1966</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Engr.-Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn. R.R.</u>	9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Hollingshead</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hitchcock</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-07-8679</u>	
17. INFORMANT <u>Family Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1. Carcinomatous</u> DUE TO (b) <u>2. Marked Myelophthoric anemia</u> DUE TO (c) <u>3. Aspiration Pneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1966</u> to <u>May 18, 1966</u> that (I) (we) last saw the deceased alive on <u>May 17, 1966</u> and that death occurred at <u>6:55 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>JAMES H. HAMED</u>		22b. DATE SIGNED <u>May 18, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES H. HAMED</u>		22d. ADDRESS <u>1227 Dulaney Valley Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 21, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Parkville, Maryland</u>	
24. FUNERAL DIRECTOR <u>John Burns" Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>MAY 23 1966</u>	



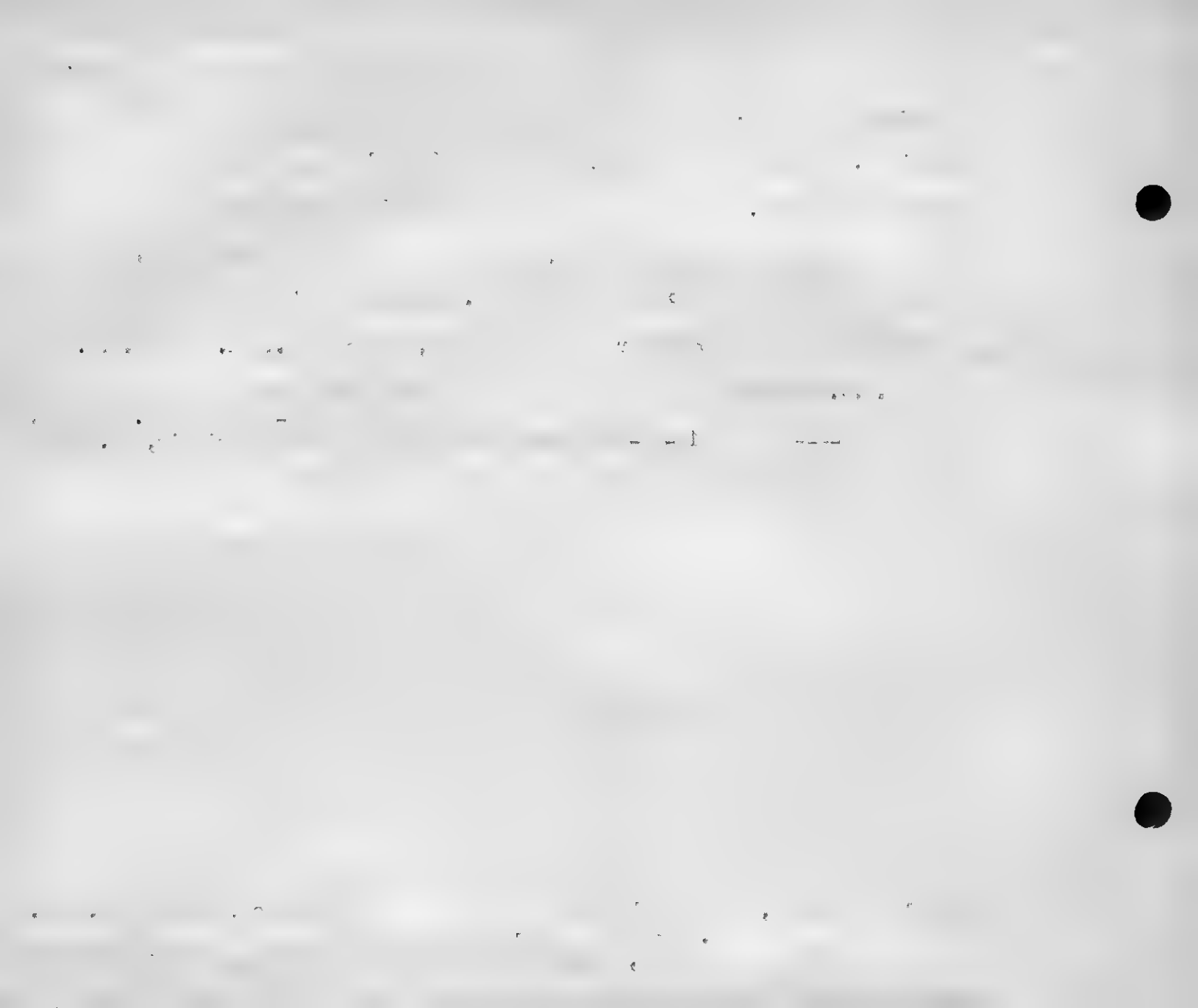
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>County Baltimore,</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville,</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>College Manor, Inc.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b> d. STREET ADDRESS <b>141 North Main Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Elizabeth Finney Hopkins.</b>			4. DATE OF DEATH <b>May 20, 1966</b>			5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>Sept. 23, 1887</b>			9. AGE (in years last birthday) <b>78</b> yrs.			IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Bel Air, Harford Co., Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>J.T.C. Hopkins</b>						14. MOTHER'S MAIDEN NAME <b>Amanda Evans Wylie</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <b>214-46-8965</b>					
17. INFORMANT (Daughter) <b>838-6677</b>						141 N. Main St. <b>21014</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (b) <b>A.A.S.C.V.D.</b> (a), stating the underlying cause last. (c) <b>Diabetes Mellitus.</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>30+ yrs.</b> <b>7 yrs.</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>5/15</b> to <b>5/20</b> , 1966, that (I) (we) last saw the deceased alive on <b>5/18</b> , 1966, and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Edwin R. Garrett</b>						22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) <b>W. Broadway &amp; Williams</b>		
22d. ADDRESS <b>11 E. Chase St., Baltimore 2, Md.</b>						22e. REC'D BY REGISTRAR <b>MAY 23 1966</b>			22f. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>May 23, 1966</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Darlington Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Darlington, Harford Co., Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph William Foster</b>											

Joseph William Foster





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. CDUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>--</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3400 Old Post Drive</u>						d. STREET ADDRESS <u>3400 Old Post Drive</u>					
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>HORWITZ</u> Last <u>--</u>						4. DATE OF DEATH Month <u>MAY</u> Day <u>20</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York City</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Isaac Siegel</u>						14. MOTHER'S MAIDEN NAME <u>Anna Kay</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Mrs. Bernice Lebow--</u>			Address <u>Same</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 47-1 DUE TO (b) <u>Arteriosclerosis of Coronary Arteries</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>arteries</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1958</u> to <u>5-18, 1966</u> , that (I) (we) last saw the deceased alive on <u>5-12, 1966</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Invin Sauber</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-19-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Invin Sauber</u>						22d. ADDRESS <u>6905 Park Heights Ave.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>MAY 20, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS INC. 6010 Reist Rd.</u>						25a. REC'D BY REGISTRAR <u>MAY 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



## CERTIFICATE OF DEATH

06546

06540

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Isaiah</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Masonic Home</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Blaytor</u> First Middle Last <u>Howard</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1892</u>
9. AGE (in years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Change Md. Motorist</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William H. Howard</u>		14. MOTHER'S MAIDEN NAME <u>Lizza Wyson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-20-1927</u>	
17. INFORMANT <u>Records of Md. Masonic Homes</u>		Address <u>Cockeysville Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1 Anterolateral Heart Disease</u> <u>4200</u> DUE TO (b) <u>3 Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 15, 1965</u> to <u>May 25, 1966</u> , that (I) (we) lost saw the deceased alive on <u>May 25, 1966</u> , and that death occurred at <u>12 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>James H. Hamed MD</u>		22b. DATE SIGNED <u>May 25, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES H. HAMED MD</u>		22d. ADDRESS <u>Masonic Home</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>May-27-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Coke Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown MD</u>
24. FUNERAL DIRECTOR <u>Wm. C. Brooks-Townson</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>1050 York Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 31 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 19. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>Baltimore - Rural</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Martin's Lagoon - Essex, Maryland</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - Rural (Essex)</b> d. STREET ADDRESS <b>530 Compass Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LEWIS JEROME JERRY L. HOYLE</b>		4 DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7/16/51</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Schooling</b>		10b KIND OF BUSINESS OR INDUSTRY <b>N. Carolina</b>	
11 BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Robert L. Hoyle</b>		14 MOTHER'S MAIDEN NAME <b>Helma Rudisill</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOCIAL SECURITY NO. (If yes give war or dates of service)	
17 INFORMANT <b>Mother (same as above)</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Apparently drowned while swimming</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>5</b> p.m. <b>19 66</b>		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Lagoon</b>		20f (City or town) (County) (State) <b>Baltimore - Baltimore, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Rudiger Breiteneker, M.D.</b>		22. DATE SIGNED <b>5/25/66</b>	
EXAMINER'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>5/28/66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	23d LOCATION (City or town) (County) (State) <b>Balto. Co. Md.</b>
24 FUNERAL DIRECTOR <b>Connelly Sons 300 Race Ave. Balto. 21</b>		25a REC'D BY REGISTRAR <b>MAY 27 1966</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
C6548 CERTIFICATE OF DEATH 6542									
1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <input checked="" type="checkbox"/>				
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>17 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 21226</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>					d. STREET ADDRESS <b>1625 SPRUCE STREET</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>CARROLL CHARLES HURTT</b>					4. DATE OF DEATH Month Day Year <b>MAY 3 19 66</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/26/97</b>		9. AGE (In years last birthday) <b>69 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BAKERY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>			12. CIT. ZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>CHARLES C. HURTT</b>					14. MOTHER'S MAIDEN NAME <b>ANNA T. PIECEY</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>218 10 7978</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA TONGUE WITH METASTASIS TO RIGHT LUNG</b> DUE TO (b) <b>BRONCHOPNEUMONIA</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST (c)									INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/16/66</b> , 19__, to <b>5/3/66</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>5/3/66</b> , 19__, and that death occurred at <b>3:15 PM</b> , from causes on and on the date stated above.									
22a. SIGNATURE <i>Haroon M. Qazi</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/3/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>HAROON M. QAZI, M. D.</b>					22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>May 6, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>GEORGE J GONCE FUNERAL HOME</b>					25a. SIGNED BY REGISTRAR <b>1966</b>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		
ADDRESS <b>RITCHIE HIGHWAY, BALTIMORE, MD.</b>									



11-11-11

11-11-11





CERTIFICATE OF DEATH

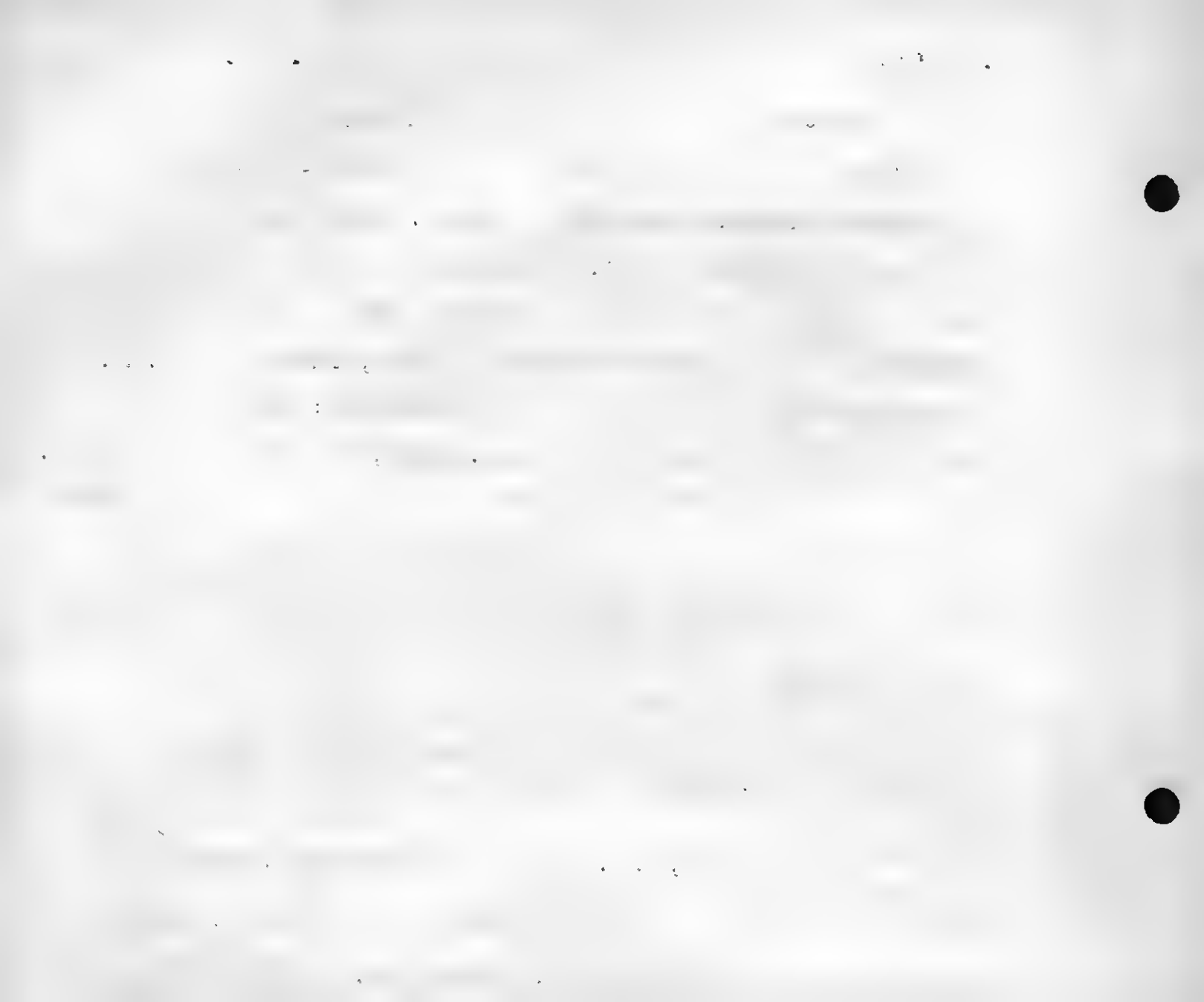
06543

06543

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>64 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE - 21229</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>					d. STREET ADDRESS <b>264 S. Loudon Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALBERT F. HUTCHINS</b>				4. DATE OF DEATH Month Day Year <b>MAY 27 19 66</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1900 MARCH 8, 1895</b>		9. <b>66</b> (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CITY OF BALTIMORE</b>		11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT HUTCHINS</b>				14. MOTHER'S MAIDEN NAME <b>ROBINETTE MN: XOXOX SCHOOL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>216 01 72 55</b>		17. INFORMANT <b>MRS. IRENE HUTCHINS 264 S. LOU- CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. DON</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF LARYNX</b> 161X DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>3/24/66</b> , 19__, to <b>5/27/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>5/27/66</b> , 19__, and that death occurred at <b>5:00AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Milton Ginsberg</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-31-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>4107 HUBBARD FUNERAL HOME WILKINS AVE. BALTIMORE, MD.</b>				25a. REC'D BY REGISTRAR <b>MAY 31 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



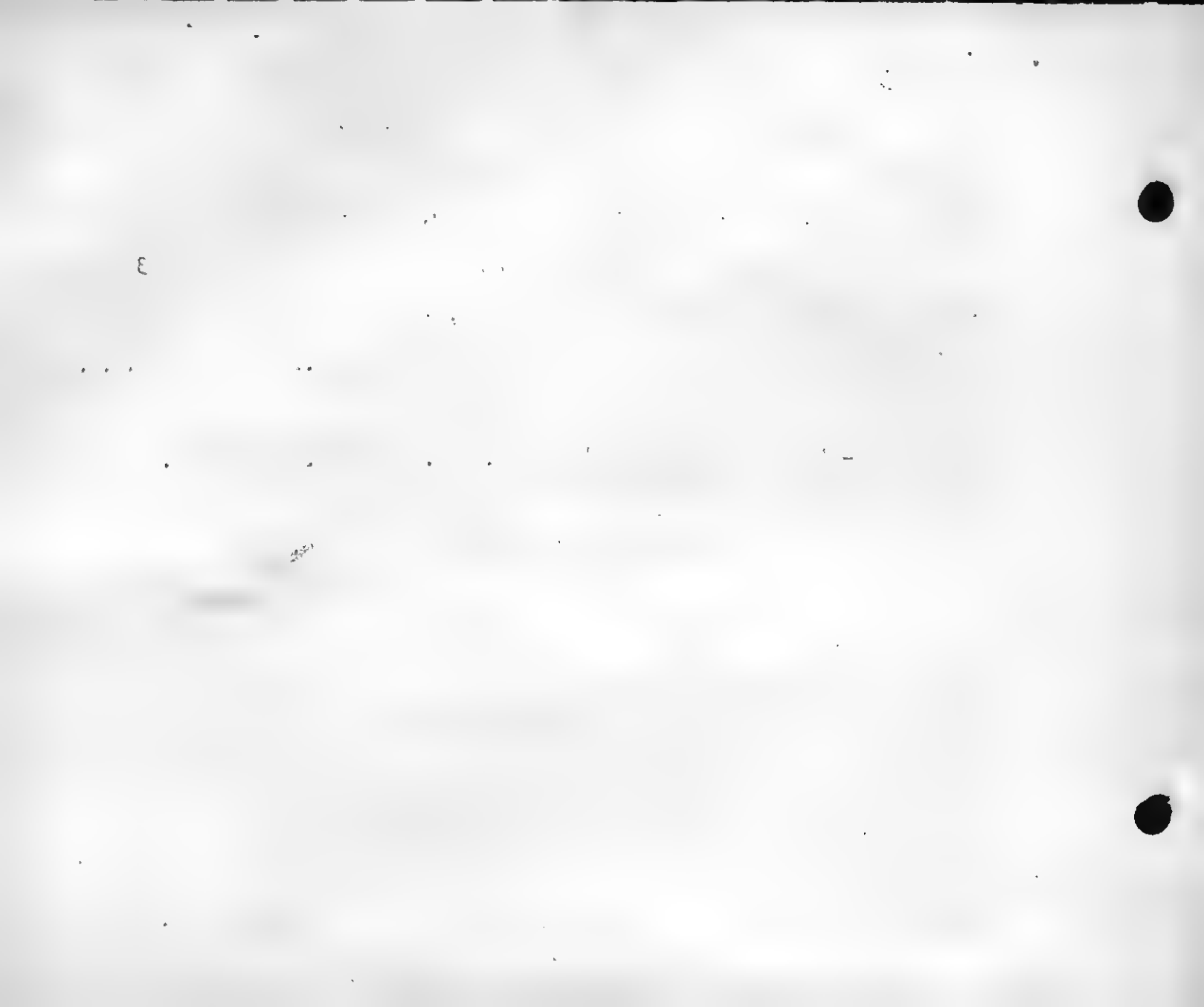
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN ID <b>15 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>607 N. DENNISON STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>JACKSON</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>3</b> Year <b>1966</b>									
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 8, 1921</b>	9. AGE (in years last birthday) <b>44</b> yrs.	10. UNDER 1 YEAR Months <b>4</b>	11. UNDER 24 HRS. Days <b>4</b>	12. Hours <b>4</b>	13. Min. <b>4</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>		11. BIRTHPLACE (State or foreign country) <b>ANNE ARUNDEL CO., MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Albert L. Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Susie</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> WW-11		16. SOCIAL SECURITY NO. <b>215 16 1054</b>		17. INFORMANT <b>CLIN. REC., VAH, FT. HOWARD, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 42-1 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO <b>MYOCARDIAL INFARCTION</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <b>Theo C. Patterson</b> EXAMINER'S NAME (Type) <b>THEO. C. PATTERSON</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>5/3/66</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-9-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MD.</b>					
24. FUNERAL DIRECTOR <b>Morton &amp; Dyett Funeral Home</b> <b>1701 Laurens St. Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>MAI U</b>		25b. REGISTRAR'S SIGNATURE <b>James</b>		1966					



FOR STATE  
HEALTH DEPT

06551

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06545

1 PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON - 4</b>		c LENGTH OF STAY in 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph</b>		d STREET ADDRESS <b>228 S. Highland Ave.</b>	
3 NAME OF DECEASED (Type or print) First <b>Margarete</b> Middle <b>A.</b> Last <b>Johnson</b>		4 DATE OF DEATH Month <b>5</b> Day <b>14</b> Year <b>19 66</b>	
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Nov. 15, 1942</b>
9 AGE (In years last birthday) yrs <b>23</b>		10 IF UNDER 1 Year Months Days Hours Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12 KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13 BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		14 CITIZEN OF WHAT COUNTRY?	
15 FATHER'S NAME <b>Stephen Kovach</b>		16 MOTHER'S MAIDEN NAME <b>Geneva George</b>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		18 SOCIAL SECURITY NO	
19 INFORMANT <b>Edward J. Johnson</b>		Address <b>228 S. Highland Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral edema, severe</b> DUE TO 237X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Brain tumor</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Rudiger Breiteneker</b> M.D.		22. DATE SIGNED <b>5/15/66</b>	
EXAMINER'S NAME (Type) <b>Rudiger Breiteneker</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>5-17-1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore, County, Maryland</b>
24. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc. 1901 Eastern Ave.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 16 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Once along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, along with carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if an event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>BAITMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>1043 QUANTREL WAY</b>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>M.</b> Last <b>JOHNSON</b>		4. DATE DEATH <b>MAY 25 19 66</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3/22/1900</b>
9 AGE (In years last birthday) <b>66</b> yrs		10 IF UNDER 1 YEAR Months <b>25</b> Days <b>19</b> Hours <b>66</b> Min.	
11a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		11b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>GINNY MN: UNKNOWN</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW II</b>		16 SOCIAL SECURITY NO <b>217 03 17 65</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>THROMBOSIS OF LEFT MIDDLE CEREBRAL ARTERY</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b> DUE TO (c)		INTERVAL BETWEEN DAYS AND DEATH <b>DAYS</b> <b>YEARS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>5/24/66</b> , 19 to <b>5/25/66</b> , 19, that (I) (we) saw the deceased alive on <b>5/25/66</b> , 19, and that death occurred at <b>10P</b> M, from causes and on the date stated above.		22a. SIGNATURE <b>SHELDON E. KALMUTZ, M. D.</b>	
22b. DATE SIGNED <b>5/25/66</b>		22c. PHYSICIAN'S NAME (Type) <b>SHELDON E. KALMUTZ, M. D.</b>	
22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>		22e. REC'D BY REGISTRAR <b>31 1966</b>	
22f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
23b. DATE THEREOF <b>5/27/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDEN PARK NATIONAL</b>	
23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>		24. FUNERAL DIRECTOR <b>ZANNINO FUNERAL HOME</b>	
24b. ADDRESS <b>257 S. CONKLING ST. BALTIMORE, MD.</b>		25a. REC'D BY REGISTRAR <b>31 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>5/27/66</b>	





**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

06542

VR ATSM (5)  
6M 1/66

**MEDICAL CERTIFICATION**



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

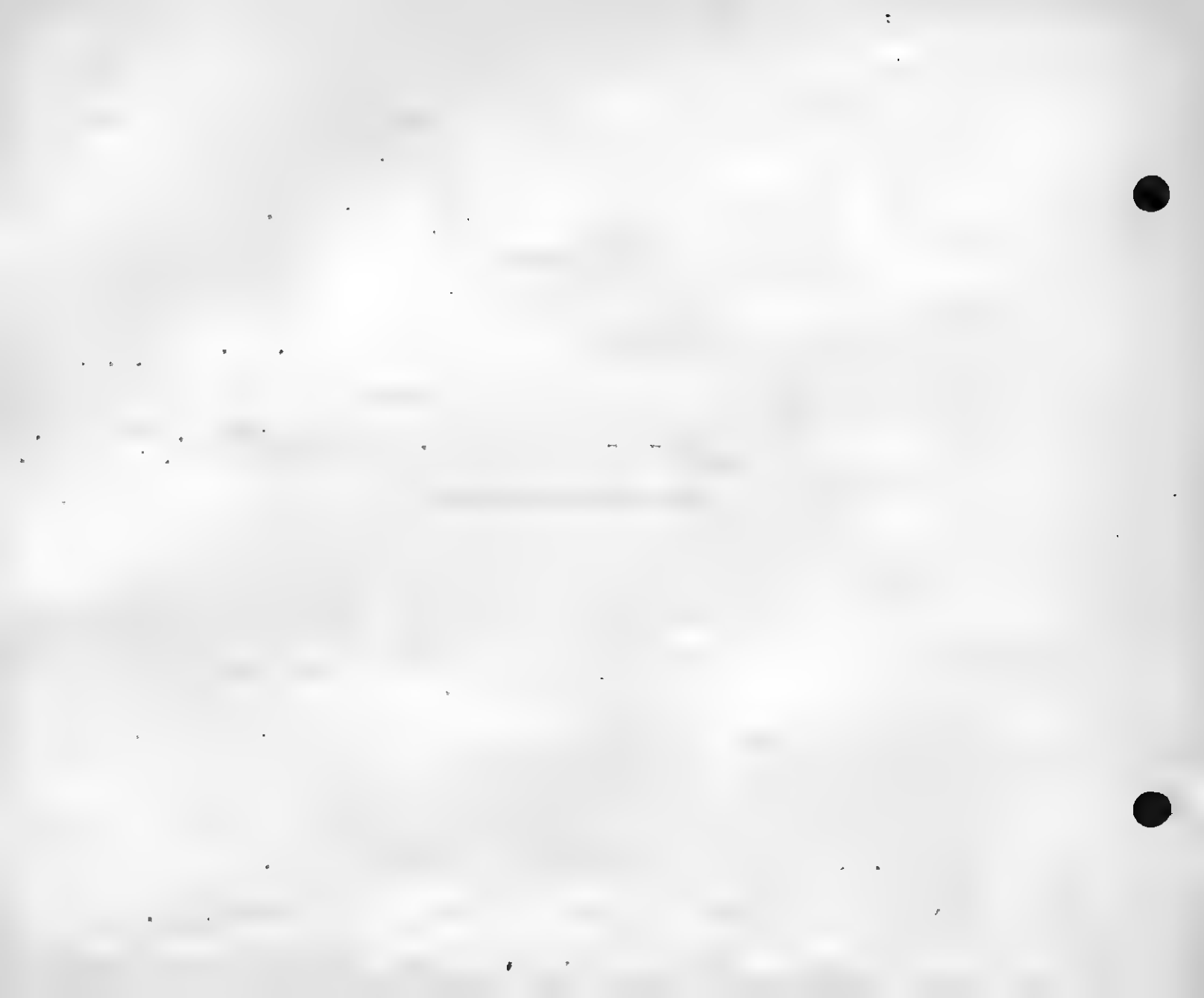
VR AISME (5)  
SM 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>43 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Timber Grove Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Volney</b> Middle <b>Louis</b> Last <b>Johnston</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/3/1886</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	9. AGE (in years last birthday) <b>79</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Charlestown W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-05-2857</b>	
17. INFORMANT <b>John K. Johnston</b>		Address <b>7392 S. Arton Ct., Hanover, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide Poisoning</b> <b>9731</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stuck garden hose up tail pipe of car &amp; ran hose in car window and started car.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>XX</b> <b>unknown p.m. May 24 19 66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	
20f. (City or town) <b>Owings Mills, Balto., Md.</b>		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D., 6 Hanover Rd., Reisterstown, Md.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/28/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Finksburg Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Finksburg, Md.</b>	
24. FUNERAL DIRECTOR <b>H. J. Eckhardt</b>		25a. REC'D BY REGISTRAR <b>MAY 31 1966</b>	
ADDRESS <b>Owings Mills, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME  
5M 1/63

06555

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06549

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MIDDLE RIVER</b>				c. LENGTH OF STAY IN lb <b>20 YRS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MARTIN CO. MARTIN BLVD.</b>				d. STREET ADDRESS <b>RT 16 BOX 165 BIRD RIVER RD</b>			
3. NAME OF DECEASED (Type or print) <b>CHARLES S. JONES</b>				4. DATE OF DEATH <b>MAY 31 1964</b>			
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 27, 1904</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAYOUT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARTIN CO.</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES JONES</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE LINDSAY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-14-2666</b>		17. INFORMANT <b>MRS GRACE MARIE JONES RT 16 BOX 165</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF DEATH <b>4:15 p.m.</b> Month, Day, Year <b>5/31 1964</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Factory</b>		20f. (City or town) <b>Essex</b> (County) <b>Baltimore</b> (State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Theo C. Patterson</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>THEOC. PATTERSON</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 4, 1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BELAIR MEM GARDENS</b>		22d. LOCATION (City, town, or county) <b>HARFORD CO. MD.</b> (State)	
23. FUNERAL DIRECTOR <b>Leach Funeral Home 7901 Belair Rd. #36</b>				24a. REC'D BY REGISTRAR <b>JUN 3 1966</b> 24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (SF)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06556

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06550

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) ✓ a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural - Baltimore</b>		c. LENGTH OF STAY IN lb <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove Hospital</b>		d. STREET ADDRESS <b>1635 Edmondson Ave.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Louis E. Jones</b>		4. DATE OF DEATH Month Day Year <b>5 9 66</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) yrs <b>52 57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GEN. CONTRACT.</b>	
11 BIRTHPLACE (State or foreign country) <b>HOWARD CO. MD</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM F JONES</b>		14. MOTHER'S MAIDEN NAME <b>CARRIE GILES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>216-10-8784</b>	
17. INFORMANT <b>ARCHIE JONES</b>		Address <b>2014 Edmondson Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Arteriosclerotic and hypertensive cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		22. DATE SIGNED <b>5/10/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/14/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT AUBURN</b>
23d. LOCATION (City or Town) (County) (State) <b>Baltimore</b>		23e. REC'D BY REG. STRAR DATE <b>MAY 12 1966</b>	
24. FUNERAL DIRECTOR <b>Marlene Pflanz</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





06557

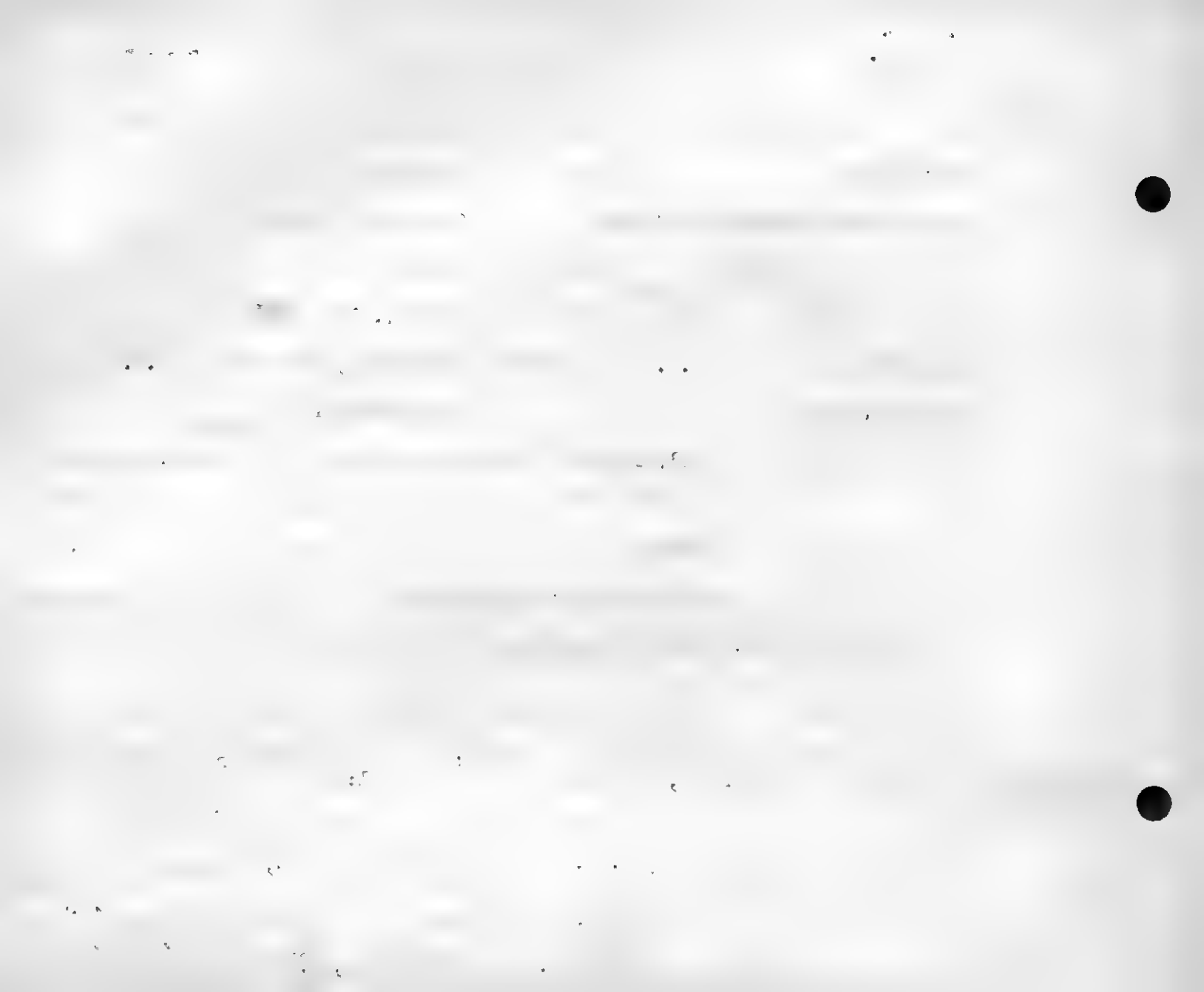
## CERTIFICATE OF DEATH

06551

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>7 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b> d. STREET ADDRESS <b>120 DELAWARE AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WARNER JAMES JONES</b>		4. DATE OF DEATH Month Day Year <b>MAY 25 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 7, 1917</b>
9. AGE (In years last birthday) <b>49 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>4 22 44</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CUSTODIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. POST OFFICE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WHITE HAVEN, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>FRAMONE JONES</b>		14. MOTHER'S MAIDEN NAME <b>HELEN BRADLEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>217 10 36 11</b>	
17. INFORMANT <b>VA HOSPITAL CLINICAL RECORDS</b>		18. FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> 441x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>UREMIA</b> DUE TO (c) <b>ARTERIOULAR NEPHROSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 HOURS</b> <b>2 MONTHS</b> <b>3 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE, MALIGNANT PHASE</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I (this hospital) attended the deceased from <b>MAY 18</b> , 19 <b>66</b> , to <b>MAY 25</b> , 19 <b>66</b> that (we) last saw the deceased alive on <b>MAY 25</b> , 19 <b>66</b> , and that death occurred at <b>1:30AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Neilson Neilson, M.D.</i>		22b. DATE SIGNED <b>5/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILSON NEILSON, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5-28-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREEN ACRES CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>SALISBURY, MARYLAND</b>
24. FUNERAL DIRECTOR <i>Louella B. Jolley</i>		25. REC'D BY REGISTRAR <b>MAY 31, 1966</b>	
26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		27. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death).



## CERTIFICATE OF DEATH

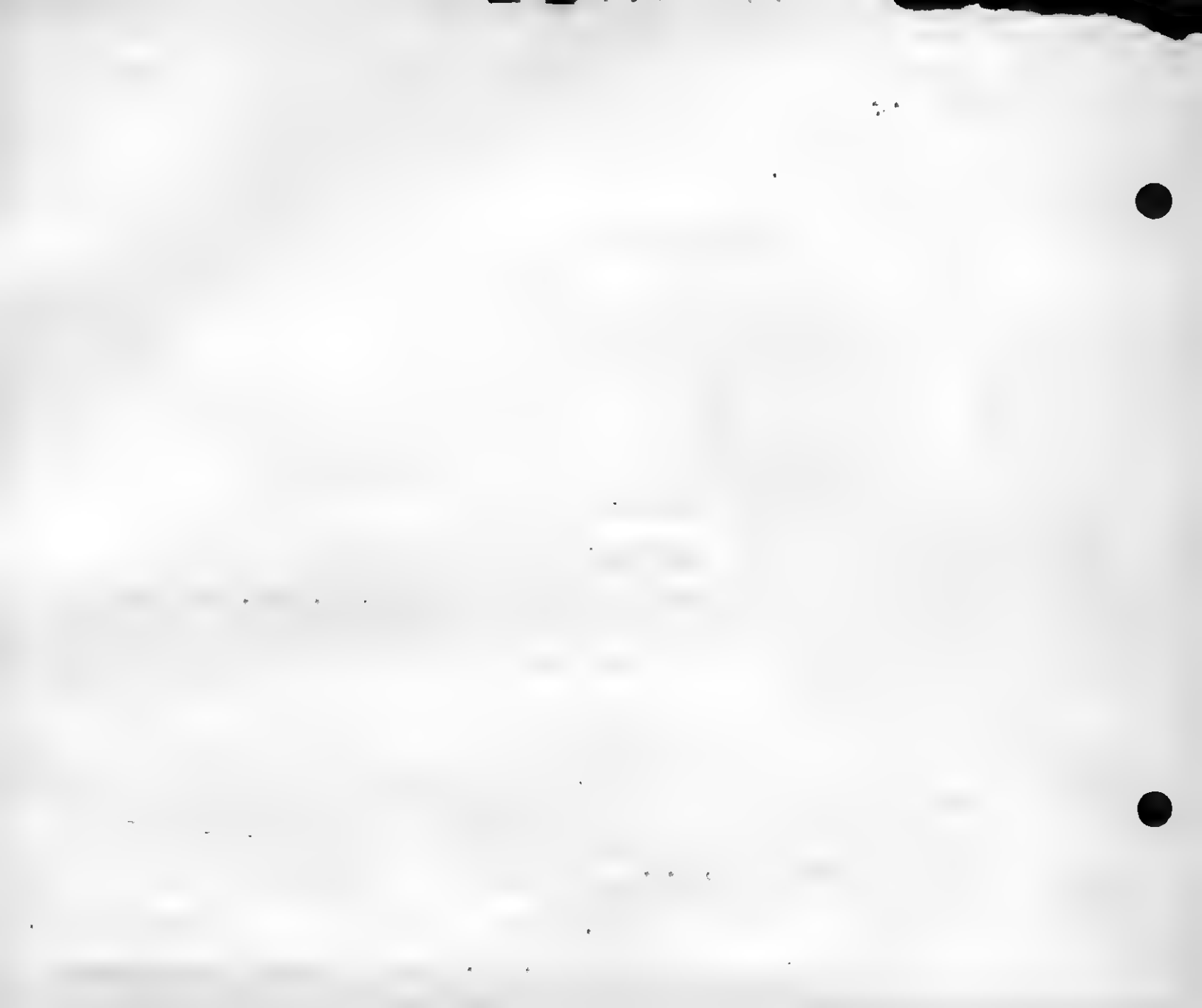
CG558

06552

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>34 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE CITY</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>2501 N. CALVERT ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELMIRA</b> Middle <b>JOYCE</b> Last <b>MAY</b>				4. DATE OF DEATH Month <b>22</b> Day <b>19</b> Year <b>66</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1874</b>	9. AGE (In years last birthday) <b>92</b>	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>		12. CIT ZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE DUBBS</b>				14. MOTHER'S MAIDEN NAME <b>LUCY ANN ROSER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Record</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Malnutrition</b> DUE TO (c) <b>Generalized Arteriosclerosis, Art. Scler. Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>(#)</del> (this hospital) attended the deceased from <b>JAN 15</b> , 19 <b>32</b> , to <b>MAY 22</b> , 19 <b>66</b> , that <del>(#)</del> (we) last saw the deceased alive on <b>MAY 22</b> , 19 <b>66</b> , and that death occurred at <b>8:25 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Imre Kopits</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5-22-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Imre Kopits, M.D.</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/25/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Tipton-Eline</b> ADDRESS <b>Hampstead, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 26 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH																													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																													
CERTIFICATE OF DEATH																													
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson 4</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson 4</u> d. STREET ADDRESS <u>24 Clarendon Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																								
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>Bowling</u> Last <u>KANE</u>					4. DATE OF DEATH Month <u>MAY</u> Day <u>21</u> Year <u>1966</u>																								
5. SEX <u>F</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/5/85</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.																					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>																					
13. FATHER'S NAME <u>Louis Henry Bowling</u>					14. MOTHER'S MAIDEN NAME <u>Emma Alice Hunter</u>																								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>none</u>					16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT <u>Mr. Leroy Kane, 24 Clarendon Ave, Towson, Md.</u>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure with uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic pyelonephritis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerotic cardiovascular disease</u>										INTERVAL BETWEEN ONSET AND DEATH																			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from <u>5-3</u> , 19 <u>66</u> , to <u>5-21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-20</u> , 19 <u>66</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.										22a. SIGNATURE <u>Mercedes O. Alcantara</u>										22b. DATE SIGNED <u>5-21-66</u>									
22c. PHYSICIAN'S NAME (Type) <u>MERCEDES O. ALCANTARA</u>					22d. ADDRESS <u>GBMC, 67CIN</u>					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22f. ADDRESS														
23a. BURIAL, CREMATION REMOVAL (Specify)					23b. DATE THEREOF <u>May 24, 1966</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Windsor Hills Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>														
24. FUNERAL DIRECTOR <u>Frank H. Newell</u>										REC'D BY REGISTRAR <u>2</u> 1966										REGISTRAR'S SIGNATURE <u>[Signature]</u>									

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06550

06554

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Balt. County Gen. Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balt.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore (21207)</u> d. STREET ADDRESS <u>3625 Forest Garden Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>I</u> Last <u>Katz</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1966</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May - 1888</u>		9. AGE (in years last birthday) <u>82</u> yrs.		10. FUNERAL 1 YEAR UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>				11. BIRTHPLACE (County & State, or foreign country) <u><del>Latvia</del> Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>															
13. FATHER'S NAME <u>Israel Katz</u>				14. MOTHER'S MAIDEN NAME <u>Dina Rae Block</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-26-965</u>				17. INFORMANT Address <u>Forest Garden</u> <u>Mrs Violet Zlotowicz - 3625</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> <u>Interossealitic Cerebro-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular disease</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>												INTERVAL BETWEEN ONSET AND DEATH <u>  </u>															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from <u>4-26</u> , 19 <u>66</u> , to <u>5-5</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>5-5</u> , 19 <u>66</u> , and that death occurred at <u>5:50</u> AM, from the causes and on the date stated above.																											
22a. SIGNATURE <u>L. B. Lerma</u>												22b. DATE SIGNED <u>5/5/66</u>															
22c. PHYSICIAN'S NAME (Type) <u>L. B. LERMA</u>												22d. ADDRESS <u>B. C. G. Z.</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>May 6/66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Ohel Yehov</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore, Md</u>															
24. FUNERAL DIRECTOR <u>El Herman &amp; Bros</u>												25a. REC'D BY REGISTRAR <u>  </u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											





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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06555									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>House in the Pines, Catonsville, Md.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>Franklin Hotel</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Katz</u> Last <u>Katz</u>			4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>216-82-9495</u>		17. INFORMANT <u>Mr. Jerry Sopher</u> Address <u>353 Equitable Bldg. #2</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Regeneration</u> + 100% DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>10 yrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>9-10-</u> , <u>1965</u> to <u>5-19-</u> , <u>1966</u> , that (I) (we) last saw the deceased alive on <u>5-19-</u> , <u>1966</u> , and that death occurred at <u>9:10 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Wilmer R. Gallagher, Jr.</u>								22b. DATE SIGNED <u>5-20-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilmer Gallagher</u>					22d. ADDRESS <u>6209 Frederick Avenue-21228 Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/20/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. 6010 Reisterstown Rd.</u>					25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		



FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06562

06556

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus Catonsville</b>		c LENGTH OF STAY IN 1b <b>Arbutus</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1216 North Avenue Shengri-La Nurs.</b>		d STREET ADDRESS <b>1216 North Avenue</b>	
3 NAME OF DECEASED (Type or print) <b>BERTHA KAUFHOLD</b>		4 DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>19 66</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>5-12-89</b>
9 AGE (In years lost birthday) <b>77 yrs</b>		10 IF UNDER 1 YEAR Months <b>77</b> Days <b>19</b> Hours <b>66</b> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>(Late) Charles Hoetzel</b>		14. MOTHER'S MAIDEN NAME <b>(Late) Katherine</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Mrs. Mildred Franz-5611 Oakland Rd.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Encephalomalacia</b> DUE TO (b) <b>Overdose of sedatives and tranquillizers</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease.</b>			INTERVAL BETWEEN ONSET AND DEATH
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic cardiovascular disease.</b>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.) <b>Overdose of sedatives and tranquillizers (types unspecified)</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>4/4</b> 19 <b>66</b> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f (City or town) (County) (State) <b>Arbutus Balto. Md.</b>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D.		22. DATE SIGNED <b>5/24/66</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>5-27-66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	23d LOCATION (City or Town) (County) (State) <b>Woodlawn, Md.</b>
24 FUNERAL DIRECTOR <b>Witzel F.D. - 4101 Edmondson Ave</b>		25 RECEIVED BY REGISTRAR <b>1 1966</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
06557													
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto Medical Center</u>						d. STREET ADDRESS <u>629 E 29th St</u>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>Dennis E. KAVANAUGH</u>						4. DATE OF DEATH <u>MAY 11 1966</u>							
5. SEX <u>M</u>						6. COLOR OR RACE <u>White</u>							
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>10/12/1897</u>							
9. AGE (In years last birthday) <u>68</u> yrs.						10. IF UNDER 1 YEAR <u>68</u> Months <u>11</u> Days <u>19</u> Hours <u>11</u> Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - PRODUCTION</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>BETHLEHEM STEEL</u>							
11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JAMES KAVANAUGH</u>						14. MOTHER'S MAIDEN NAME <u>KATHERINE SMALL</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WW I</u>						16. SOCIAL SECURITY NO. <u>180-03-3212</u>							
17. INFORMANT <u>MRS. MARGARET A. KAVANAUGH (SAME)</u>						Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uraemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer Bladder</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NIL</u>												INTERVAL BETWEEN ONSET AND DEATH <u>14 DAYS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <u>4.20, 1966</u> to <u>5.11, 1966</u> , that (I) (we) last saw the deceased alive on <u>5.11, 1966</u> , and that death occurred at <u>11:20 PM</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Ramesh C. Agarwal</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>												22b. DATE SIGNED <u>5.11.66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAMESH C. AGARWAL M.D.</u>												22d. ADDRESS <u>6701, N. CHARLES, BALTIMORE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>												23b. DATE THEREOF <u>5/16/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Mem. Grs. Timonium, Balto. Co. Md.</u>												23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co. 4905 York Road Baltimore 12, Md.</u>												25a. REC'D BY REGISTRAR <u>MAY 13 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>													



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## Item 8 Film G377 5/25/66 mh

### CERTIFICATE OF DEATH

06558

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN lb <u>4 MONTHS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHANGHAI NURSING HOME</u>				d. STREET ADDRESS <u>3700 MOHAWK Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARY FRANCES KEIM</u>			<b>4. DATE OF DEATH</b> Month <u>5</u> - Day <u>18</u> - Year <u>1966</u>				
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1892 APRIL 29, 1892</u>	<b>9. AGE</b> (In years last birthday) <u>74</u> yrs.	<b>IF UNDER 1 YEAR:</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>JOHN McDONOUGH</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>JULIANA REYN</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>UNKNOWN</u>		<b>16. SOCIAL SECURITY NO.</b> <u>216-14-7168</u>		<b>17. INFORMANT</b> <u>Address 2109 ARLOUNE DRIVE BALTO. MD. 21228</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF UTERINE CERVIX WITH</u> DUE TO <u>GENERALIZED METASTASES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month _____ Day _____ Year <u>19</u> Hour a. m. _____ p. m. _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that I attended the deceased from</b> <u>1-18-</u> , 19 <u>66</u> , to <u>5-18-</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>5-18-</u> , 19 <u>66</u> , and that death occurred at <u>12:10</u> AM, from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>Cesar Valle Cervero</u> M.D. <u>8624 Liberty Rd</u>				<b>DATE SIGNED</b> <u>5-18-66</u>			
<b>PHYSICIAN'S NAME (Type)</b> <u>CESAR VALLE CAVERO RANDALLS TOWN Md.</u>							
<b>22a. REMOVAL, CREMATION, BURIAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>5/20/66</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Holy Cross Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Baltimore, Md.</u>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>JOHN F. DENNY, INC. 715 Light St.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>MAY 19 1966</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, it should be filed with the general director, TO FUNERAL DIRECTOR: This certificate should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>06565</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p>06559</p> </div> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Baltimore</b> MARYLAND</p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <b>Maryland</b> b. COUNTY <b></b></p>					
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p><b>Catonville</b></p>				<p>c. LENGTH OF STAY IN 1b</p> <p><b>13 days</b></p>		<p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p><b>Baltimore</b></p>					
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</p> <p><b>SPRING GROVE STATE HOSPITAL</b></p>						<p>d. STREET ADDRESS</p> <p><b>141 South Calverton Road</b></p>				<p>e. IS RESIDENCE ON A FARM?</p> <p>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <b>Etta</b> Middle <b>V.</b> Last <b>Keller</b></p>			<p>4. DATE OF DEATH</p> <p>Month <b>5</b> Day <b>16</b> Year <b>1966</b></p>								
<p>5. SEX</p> <p><b>female</b></p>		<p>6. COLOR OR RACE</p> <p><b>white</b></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH</p> <p><b>April 22, 1894</b></p>		<p>9. AGE (In years last birthday)</p> <p><b>72 yrs.</b></p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><b>unknown Housewife</b></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p> <p><b>Domestic</b></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country)</p> <p><b>Maryland</b></p>			<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><b>U. S.</b></p>		
<p>13. FATHER'S NAME</p> <p><b>William Bolter</b></p>						<p>14. MOTHER'S MAIDEN NAME</p> <p><b>Martha Wilson</b></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</p> <p><b>unknown NO NONE</b></p>				<p>16. SOCIAL SECURITY NO.</p> <p><b>unknown</b></p>		<p>17. INFORMANT Address</p> <p><b>Records: SPRING GROVE STATE HOSPITAL</b></p>					
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular</b></p> <p>4221</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>disease</b></p> <p>DUE TO (c) <b></b></p>										<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>											
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. <b>19</b> p.m. <b></b></p>				<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (X) (this hospital) attended the deceased from <b>April 3, 1966</b> to <b>May 16, 1966</b>, that (X) (we) last saw the deceased alive on <b>May 16, 1966</b>, and that death occurred at <b>9:00 p.m.</b> from the causes and on the date stated above.</p>											
<p>22a. SIGNATURE</p> <p><b>Stella Wachslar</b></p>						<p>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>		<p>22b. DATE SIGNED</p> <p><b>5-17-66</b></p>			
<p>22c. PHYSICIAN'S NAME (Type)</p> <p><b>Stella Wachslar, M.D.</b></p>						<p>22d. ADDRESS</p> <p><b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b></p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify)</p> <p><b>BURIAL</b></p>			<p>23b. DATE THEREOF</p> <p><b>5-21-66</b></p>		<p>23c. NAME OF CEMETERY OR CREMATORY</p> <p><b>Holy Cross</b></p>			<p>23d. LOCATION (City, town or county) (State)</p> <p><b>Anne Arundel Cty, Md</b></p>			
<p>24. FUNERAL DIRECTOR</p> <p><b>Geo. H. Schwab Funeral Home</b></p>						<p>ADDRESS</p> <p><b>Francis W. Spiller 2101 Redwood Ave.</b></p>		<p>25a. REC'D BY REGISTRAR</p> <p><b>MAY 19 1966</b></p>		<p>25b. REGISTRAR'S SIGNATURE</p> <p><b>Charles Judge</b></p>	

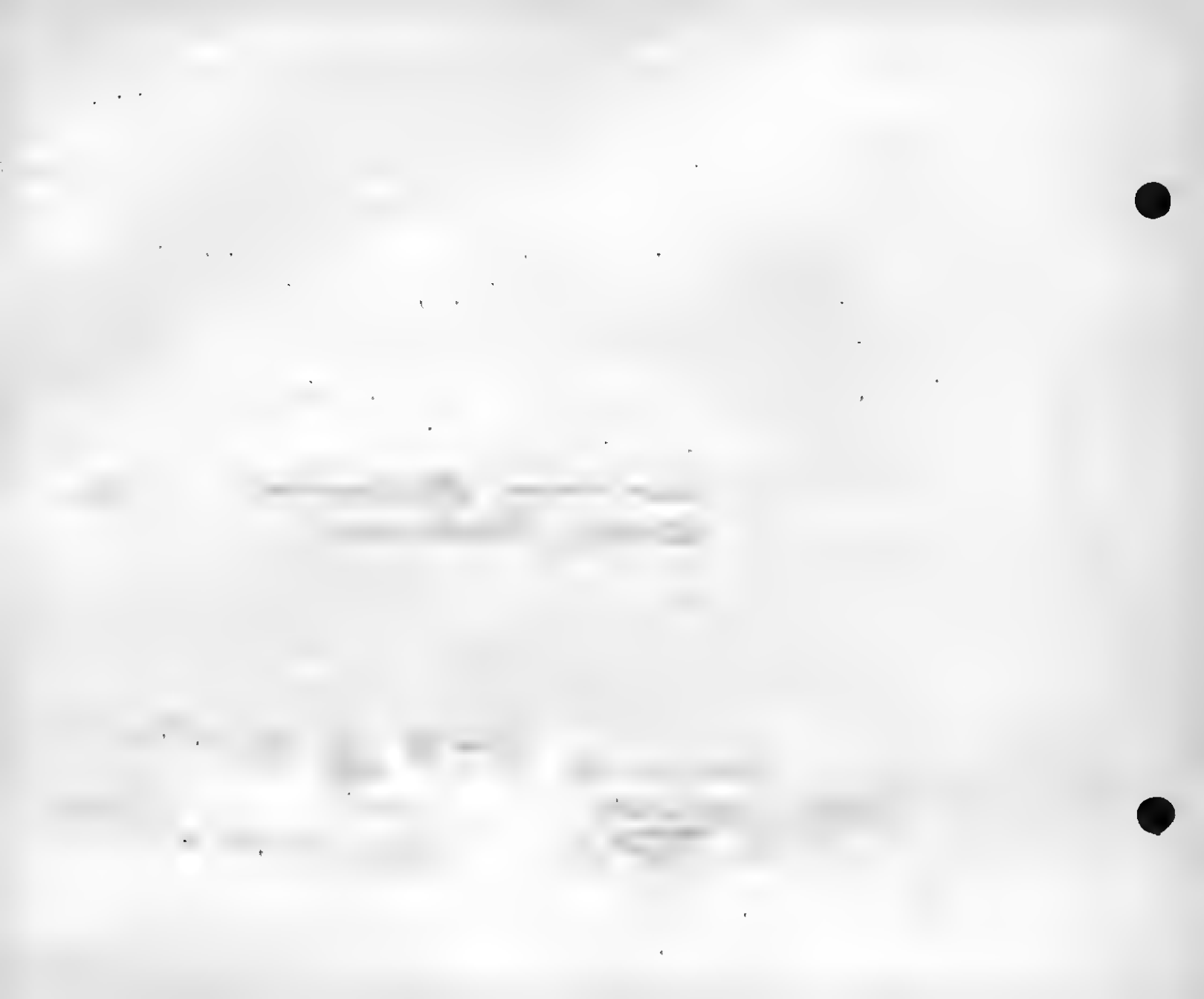


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>951 Fairmount Avenue</i>						d. STREET ADDRESS <i>951 Fairmount Avenue</i>					
3. NAME OF DECEASED (Type or print) <i>Grover P. Keller</i>						4. DATE OF DEATH Month <i>May</i> Day <i>17</i> Year <i>1966</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 8, 1885</i>		9. AGE (In years last birthday) <i>81</i> yrs.		10. FUND 1 YEAR IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired-Manager</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Transportation Lines Maryland</i>				11. BIRTHPLACE (County & State, or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Edward L. Keller</i>						14. MOTHER'S MAIDEN NAME <i>Hattie L. Michael</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Family Records</i>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>1201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio Sclerosis</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>1/2 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>May 16, 1966</i> to <i>May 17, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 17, 1966</i> , and that death occurred at <i>5:40</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Dr. Paul Byerly</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5/18/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>Dr. Paul Byerly</i>						22d. ADDRESS <i>5820 York Rd</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>May 19, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Towson, Maryland</i>			
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>						25a. REC'D BY REGISTRAR <i>May 23 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06567

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06567

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>Baltimore #14</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		e. STREET ADDRESS <b>2208 Pinewood Ave.</b>	
3 NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>E</b> Last <b>Kelly</b>		4 DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>1966</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 24, 1903</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dist. Sales Mgr.</b>		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) <b>62</b> IF UNDER 1 YEAR Months <b>22</b> Days <b>22</b> Hours <b>19</b> Min. <b>66</b>
11 BIRTHPLACE (State or foreign country) <b>Penna.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Edward Kelly</b>		14. MOTHER'S MAIDEN NAME <b>Rhoda McKee Snively</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <b>No</b>		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Mrs. Ruth M. Kelly</b>		Address <b>(Same)</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Respiratory Distress</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Several years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles O'Donnell</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles O'Donnell</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/25/66.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24 FUNERAL DIRECTOR <b>L. J. Buck Inc 5305 Hayford Rd</b>		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
26. DEC'D BY REGISTRAR <b>MAY 24 1966</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06568

## CERTIFICATE OF DEATH

06562

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN b <b>33 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp'tal, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived if institut on Residence before adm ssion) a. STATE <b>MARYLAND</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>2115 N. Fulton Avenue</b> e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN CARROLL KELLY</b> First Middle Last 4. DATE OF DEATH <b>5 11 19 66</b> Month Day Year		5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>1/8/86</b> 9. AGE (in years lost birthday) <b>80</b> yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED PAINTER</b> 11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MICHAEL KELLY</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b> 16. SOCIAL SECURITY NO <b>216 01 07 39</b>		14. MOTHER'S MA-DEN NAME <b>KATHERINE CARROLL</b> 17. INFORMANT <b>CLINICAL RECORDS</b> Address <b>V.A. HOSPITAL, FORT HOWARD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>465X INFARCTION OF LUNGS</b> DUE TO (b) <b>PULMONARY EMBOLI</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>ARTERIOSCLEROTIC HEART DISEASE WITH INFARCTION OF MYOCARDIUM AND MURAL THROMBI</b>		INTERVAL BETWEEN DAYS AND DEATH <b>DAYS</b> <b>DAYS</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>4/8</b> , 19 <b>66</b> to <b>5/11</b> , 19 <b>66</b> that (X) (we) last saw the deceased alive on <b>5/11</b> , 19 <b>66</b> , and that death occurred at <b>2:45 M. from</b> causes and on the date stated above			
22a. SIGNATURE <b>J. D. Talbert</b> 22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22b. DATE SIGNED <b>5/11/66</b> 22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>5/16/66.</b> 23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b> 23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>		24. FUNERAL DIRECTOR <b>Leonard J. RUCK FUNERAL HOME</b> 25a. REC'D BY REGISTRAR <b>MAY 13 1966</b> 25b. REGISTRAR'S SIGNATURE <b>f. Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
C6563					C6563						
1. PLACE OF DEATH a. COUNTY Baltimore County					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson					b. COUNTY PRINCE GEO						
c. LENGTH OF STAY IN 1b 9 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRANDYWINE						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital					d. STREET ADDRESS Box 436P, RTE 1						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First NORMAN			Middle KEYS		Last KEYS		4. DATE OF DEATH Month 5		Day 11		
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/10/27		9. AGE (In years last birthday) 39 yrs.		10. FINDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME UNKNOWN					14. MOTHER'S MAIDEN NAME ETHEL HOLLY						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address Hosp. records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS, ACUTE, DIS- 0021 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PULMONARY TUBERCULOSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 14 days 3 mos.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (X) (this hospital) attended the deceased from 5/2, 1966, to 5/11, 1966, that (X) (we) last saw the deceased alive on 5/11, 1966, and that death occurred at 7:40 PM, from the causes and on the date stated above.											
22a. SIGNATURE Wm. Newcomer					22b. DATE SIGNED 5/11/66		22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent			22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5-14-66		23c. NAME OF CEMETERY OR CREMATORY Forest Hill Mem. Garden			23d. LOCATION (City, town or county) (State) Clinton, Maryland			
24. FUNERAL DIRECTOR Martell Adams					25a. REC'D BY REGISTRAR Geo. H. Adams		25b. REGISTRAR'S SIGNATURE Charles Judge				

MAY 18 1966



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>						c. LENGTH OF STAY IN 1b <b>7 Ds.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Dulaney Nursing Home</b>						e. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First <b>Ora</b> Middle <b>Love</b> Last <b>Kiddy</b>						4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 2 1889</b>		9. AGE (in years last birthday) <b>77</b> yrs.		F UNDER 1 YEAR <input type="checkbox"/> F UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>				10b. KIND OF BUSINESS OR <b>Hospital</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Allegany Md.</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas A. Kiddy</b>						14. MOTHER'S MAIDEN NAME <b>Ora Love</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>020-30-0304A</b>		17. INFORMANT <b>John Roberts</b>				Address <b>Barton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>15 yrs</b>										INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 4 1966</b> to <b>May 7 1966</b> , that (I) (we) last saw the deceased alive on <b>May 4 1966</b> , and that death occurred at <b>5:40 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>A. Allan Smith</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/7/66</b>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>5/10/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>				23d. LOCATION (City, town or county) (State) <b>Moscow Mills Md.</b>	
24. FUNERAL DIRECTOR <b>E. L. Brual</b>						ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 is to be retained by the hospital or attending physician. Page 1 is to be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 62

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
06571														
06565														
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> c. LENGTH OF STAY IN b <b>50 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer Park Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> d. STREET ADDRESS <b>Deer Park Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Charles Samuel Knight</b>					4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1966</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 15, 1879</b>		9. AGE (In years last birthday) <b>87 yrs.</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Overseer (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Woolen Company</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Carroll County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>								
13. FATHER'S NAME <b>Jacob W. Knight</b>					14. MOTHER'S MAIDEN NAME <b>Mary Schmidt</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>215-05-1977</b>					17. INFORMANT <b>Mrs. Marthe K. Knight</b> Address <b>Deer Park Rd. Reisterstown, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause pertinent for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis - generalized</b> DUE TO <b>Benign Prostatic Hypertrophy with</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause test. <b>Urinary retention</b> DUE TO <b>Urinary retention</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part I of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>November 3, 1965</b> to <b>May 3, 1966</b> that (I) (we) last saw the deceased alive on <b>May 3, 1966</b> and that death occurred at <b>12:40 PM</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>C. E. McWilliams</b>					22b. DATE SIGNED <b>May 3, 1966</b>									
22c. PHYSICIAN'S NAME (Type) <b>C. E. McWilliams M.D.</b>					22d. ADDRESS <b>11904 Reisterstown Rd Reisterstown Md</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 5, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Deer Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Reisterstown, Md.</b>								
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. J. Echhardt</b>					25a. REC'D BY REGISTRAR <b>MAY 6 1966</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of the body from any event within 72 hours after death.

VR A15ME  
GM 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Overlea Ave. &amp; Belair Road</b>		d. STREET ADDRESS <b>3907 Walnut Avenue</b>	
3 NAME OF DECEASED (Type or print) First <b>MICHAEL</b> Middle <b>KOYNE</b> Last <b>Jr</b>		4 DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7-24-1896</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bricklayers Union</b>	
13 FATHER'S NAME <b>Michael &amp; Koyne Sr.</b>		14 MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WW I</b>		16. SOCIAL SECURITY NO. <b>212-07-7692</b>	
17. INFORMANT <b>Mrs Mary F. Calligan</b>		Address <b>58 Peppermint Lane 20</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple Traumatic Injuries.</b> 8124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS A TUPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Pedestrian struck by auto.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>5/19 19 66</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	20f. (City or town) (County) (State) <b>Baltimore Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D.		22. DATE SIGNED <b>5/19/66</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		Address (Street, city, town, or county) <b>Baltimore</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-23-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Baltimore Md.</b>
24 FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		25a. REC'D BY REG. STRAR <b>MAY 23 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>





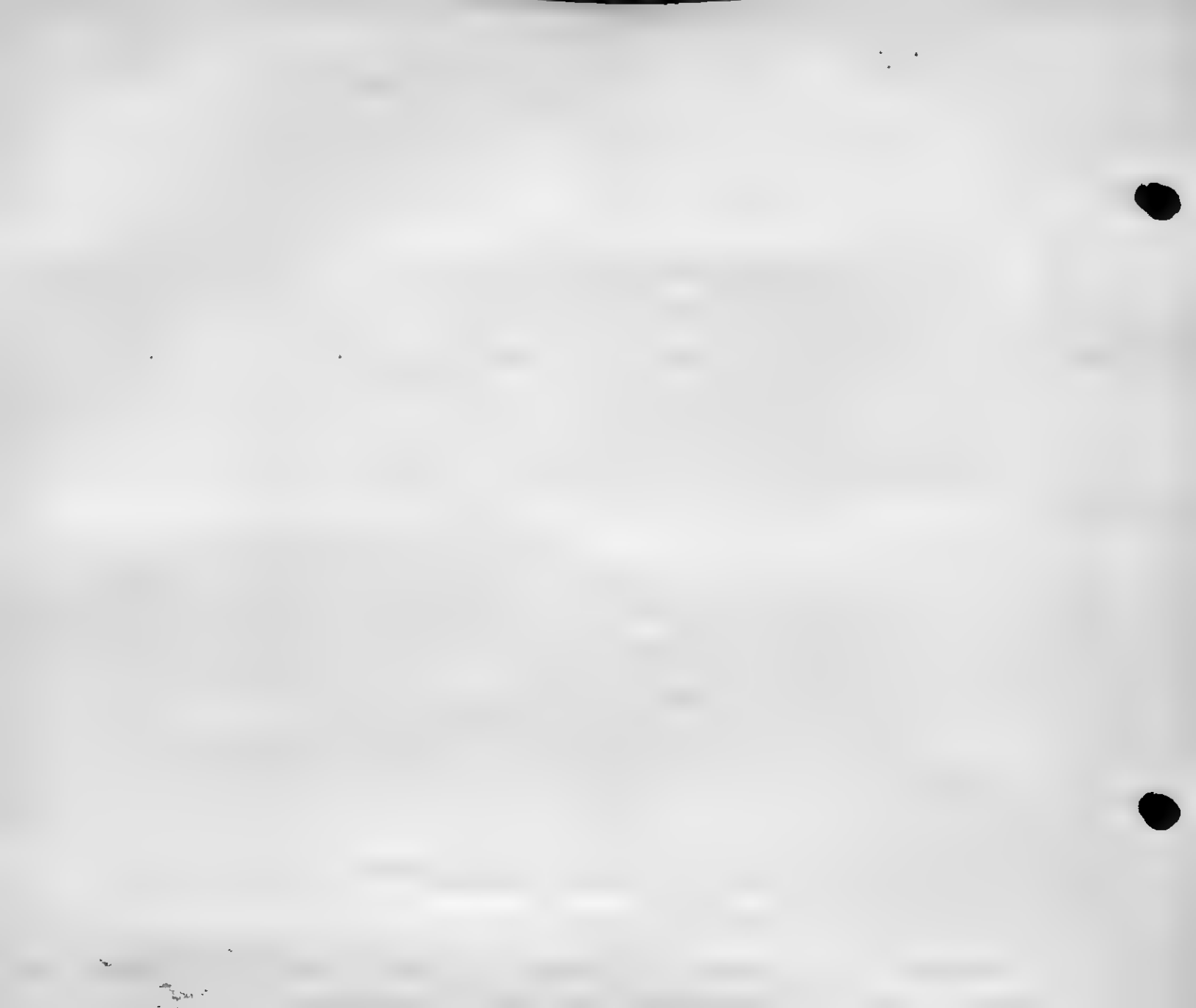
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06573

06567

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Joppa</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Old Joppa Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Joppa, Maryland</u> d. STREET ADDRESS <u>Kenwood 2415 Old Joppa Road</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Henry</u> 5. SEX <u>m</u> 6. COLOR OR RACE <u>w</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				<b>4. DATE OF DEATH</b> <u>May 3 1966</u> 8. DATE OF BIRTH <u>Feb. 1, 1877</u> 9. AGE (In years last birthday) <u>89 yrs.</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Ret. Farmer</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore Co. Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>John William Kratz</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Wilhelmina Haase</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>220-44-5915</u> <b>17. INFORMANT</b> <u>Miss Myrtle Kratz</u> Address <u>Kenwood 2415 Joppa Road</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Mesenteric thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cerebrovascular occlusion 6 yrs.</u> (c) <u>Arteriosclerotic CVD</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1959</u> <b>to</b> <u>May 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>May 3 1966</u> , <b>and that death occurred at</b> <u>9:55 PM</u> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>William A. Tyson</u> M.D.				<b>22b. DATE SIGNED</b> <u>5-3-66</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>William A. Tyson</u>				<b>22d. ADDRESS</b> <u>Kingville, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>5-7-1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lauren F. Home, Inc.</u> ADDRESS <u>7401 Belair Rd. Balto. Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>MAY 9 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles J. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

M

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06574						06568					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. LENGTH OF STAY IN IB <u>10 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5534 Ashbourne Rd</u>						d. STREET ADDRESS <u>5534 Ashbourne Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>A.</u> Last <u>KUHN</u>						4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/5/27</u>		9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dynalotron</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penn.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>William A. Kuhn</u>						14. MOTHER'S MAIDEN NAME <u>Zella Moffitt</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W. W. II</u>				16. SOCIAL SECURITY NO. <u>211-18-3054</u>		17. INFORMANT <u>Janet S. Kuhn</u> Address <u>5534 Ashbourne Rd</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenocarcinoma of rectum,</u> <u>1530</u> DUE TO <u>unresectable</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 8, 1966</u> , to <u>May 12, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 11, 1966</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Eugenio E. Benitez</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/18/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Eugenio E. Benitez</u>						22d. ADDRESS <u>3350 Wilkens Ave.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/20/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Fallston Penn.</u>			
24. FUNERAL DIRECTOR <u>Ambrose Inc. 1328 Sulphur Spring Rd</u>						ADDRESS		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06575

06569

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Baltimore</b>		c. LENGTH OF STAY IN lb <b>rural Balto. 7</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Windsor Mill Road, Balto. 7, Md</b>		d. STREET ADDRESS <b>Windsor Mill Road</b>	
3. NAME OF DECEASED (Type or print) <b>William</b> <sup>First</sup> <b>Edward</b> <sup>Middle</sup> <b>Kuntz</b> <sup>Last</sup>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>66</b>	
5. SEX <b>Male</b>	6. CO. OR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10 1874</b>
9. AGE (in years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Balto County Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Conrad Kuntz</b>		14. MOTHER'S MAIDEN NAME <b>Alice V. Macken</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-36-3854</b>	
17. INFORMANT <b>Carl E. Kuntz Box 109 Ridge Rd. Balto 7, Md</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency and</b> DUE TO <b>Cerebral Vascular Disease</b> (c) <b>5/11/66</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15-20 YRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 1</b> , 19 <b>50</b> , to <b>MAY 16</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/16</b> 19 <b>66</b> , and that death occurred at <b>6 A</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>Thomas E. Wheeler</b>		22b. DATE SIGNED <b>5/16/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas E. Wheeler M.D.</b>		22d. ADDRESS <b>3601 Clifmar Rd.</b>	
23a. BURIAL, CREMATION, REMOVA (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/19/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive, Randallstown</b>	23d. LOCATION (City or Town) (County) (State) <b>Randallstown Balto Md.</b>
24. FUNERAL DIRECTOR <b>Loring Byers 8728 Liberty Rd Randallstown</b>		25a. REC'D BY REGISTRAR <b>MAY 10 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 06570

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <b>6301 Carlynn Ave.</b>		d. STREET ADDRESS <b>6301 Carlynn Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Josephine B. Laderoute</b>		4. DATE OF DEATH Month Day Year <b>May 4, 1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/10/1879</b>
9. AGE (In years (say birthday) yrs) <b>87</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11c. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>England</b>	
13. FATHER'S NAME <b>? Lomathe</b>		14. MOTHER'S MAIDEN NAME <b>? Blanchette</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>Mr. Patrick Keller</b>		Address <b>same as 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ATHEROSCLEROTIC C-V-D.</b> DUE TO <b>CORONARY ATHEROSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HEMIPLEGIA - RIGHT</b> DUE TO <b>CEREBRAL SCLEROSIS</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>? YEARS</b> <b>7 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4-14</b> , 19 <b>66</b> , to <b>5-4</b> , 19 <b>66</b> , that I last saw the deceased alive on <b>4-14</b> , 19 <b>66</b> , and that death occurred at <b>4 P.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>5907 BUYNNY OAK AVE. BALTO. MD. 5-4-66</b>			
ACTUAL SIGNATURE <b>Leon Ashman</b>		M.D. <b>5907 BUYNNY OAK AVE. BALTO. MD. 5-4-66</b>	
PHYSICIAN'S NAME (Type) <b>Leon Ashman</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>4/5/66</b>	22c. NAME OF CEMETERY OR CREMATORY <b>O'Connor Funeral Home</b>	22d. LOCATION (City, town, or county) (State) <b>Toronto, Canada</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd. Baltimore, Maryland</b>	
24a. REC'D BY REGISTRAR <b>MAY 9 1966</b>		24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If City deoy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>BALTO.</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>BIG GUN POWDER FALLS</b>		c. LENGTH OF STAY IN 1b <b>MIDDLE RIVER</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Approx. 1½ Miles east of Rt. 40</b>		d. STREET ADDRESS <b>925 ARNCLIFF RD</b>	
3 NAME OF DECEASED (Type or print) <b>EVERETT CHARLES LAISURE JR.</b>		4 DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1966</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>DEC. - 4 - 1929</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MARTIN CO.</b>		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) yrs <b>36</b>
11 BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <b>EVERETT Q. LAISURE SR.</b>		14 MOTHER'S MAIDEN NAME <b>ESTHER GARDNER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>215-24-1248</b>	17 INFORMANT <b>PATRICIA (WIFE)</b> Address <b>SAME AS ABOVE</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carbon Monoxide</b> 7131 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>undis-</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John C. Hyle</b> MD		22. DATE SIGNED	
EXAMINER'S NAME (Type) <b>JOHN C. Hyle</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>May-18-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>
24 FUNERAL DIRECTOR <b>Connolly Sons Funeral Home - 300 Mace Ave</b>		25a. REC'D BY REGISTRAR <b>MAY 20 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME  
5M 1/63

1M

06578

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06572

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>19 Wade Ave.</b>				d. STREET ADDRESS <b>19 Wade Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>Corinne Lambie</b>				4. DATE OF DEATH Month <b>5</b> Day <b>25</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>5-5-1894</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>William B. Day</b>				14. MOTHER'S MAIDEN NAME <b>Thomas</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charles J. Lambie</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>221 Acute cardiac failure</b> <b>arterio sclerotic cardio vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Geo. S. M. Kieffer M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Geo. S. M. Kieffer</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>1010 Leeds Ave 29</b> DATE SIGNED <b>May. 25-66</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-28-66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore M D.</b>	
23. FUNERAL DIRECTOR <b>E. S. MacNabb</b> ADDRESS <b>301 Frederick Rd. 21228</b>				24b. REC'D BY REGISTRAR 24c. REGISTRAR'S SIGNATURE <b>MAY 31 1966 Charles Judge</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. CITY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>						d. STREET ADDRESS <b>3024 Chesley Avenue</b>					
3. NAME OF DECEASED (Type or print) <b>Harry H. LANGREHR</b>						4. DATE OF DEATH <b>May 16 1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-28-93</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POLICE M.N.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>LAW.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LOUIS LANGREHR</b>						14. MOTHER'S MAIDEN NAME <b>ANNA LEMMERMAN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-26-4600</b>		17. INFORMANT <b>Mrs. Julia C. Langreh</b> Address <b>SAME</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Biliary obstruction</b> <b>586X</b> DUE TO <b>Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 24</b> , 19 <b>66</b> , to <b>May 16</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 16</b> , 19 <b>66</b> , and that death occurred at <b>7:50p.</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Rostom A. Rivera</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5-16-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Rostom A. Rivera</b>						22d. ADDRESS <b>York Road, Baltimore 21204 Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>5-19-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION (City, town or county) (State) <b>BALTO MD</b>			
24. FUNERAL DIRECTOR <b>Charles H. Gromer</b>						25a. REC'D BY REGISTRAR <b>MAY 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



## CERTIFICATE OF DEATH

06580

06574

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN TB <b>30 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MILTON</b> Middle <b>JAMES</b> Last <b>LATHAM</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>8</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-17-1899</b>
9. AGE (In years last birthday) yrs <b>67</b>		10. IF UNDER 1 YEAR Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>SOLDIER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. ARMY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>DENVER CO., COLORADO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES LATHAM</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES 4-19-18/9-30-49</b>		16. SOCIAL SECURITY NO <b>214 30 3610</b>	
17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP. FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</b> DUE TO <b>WITH PARKINSONISM</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Apr. 8 19 66</b> to <b>May 8 19 66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 8, 19 66</b> , and that death occurred at <b>p. M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence F. Awalt, Jr.</i> M.D.		22b. DATE SIGNED <b>5 9 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE F. AWALT, JR., M. D.</b>		22d. ADDRESS <b>VAH, FT. HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>May 12 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Walter Funeral Home</b> <b>Pratt &amp; Stricker Sts.</b> <b>Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 11 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME 15  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft. Howard</b>		c LENGTH OF STAY IN lb <b>15 years</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft. Howard</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., Howard Avenue</b>		d STREET ADDRESS <b>Howard Avenue 21219</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LAW</b> Last <b>LAW</b>		4 DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Dec. 25- 1926</b>
9 AGE (In years at birthday) <b>39</b> yrs		10 F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Antonino Marzocchi</b>		14 MOTHER'S MAIDEN NAME <b>Mary E. Powers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>220-20-3353</b>	
17 INFORMANT <b>Husband, Mr. Robert Law, # 2, a, b, c, d.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part 1 of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <b>8</b> pm <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theodore C. Patterson</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Theodore C. Patterson M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>May 27- 1966</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		23d LOCATION (City or Town) (County) (State) <b>Dundalk, Maryland 21222</b>	
24 FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>		25 DECD BY REGISTRAR <b>MAY 27 1966</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

(M)

MD, LAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 4 Film G377 5/25/66 mh

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carney</b> c. LENGTH OF STAY IN 1b <b>Carney</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9640 Mason ave.</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Balto</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carney</b> d. STREET ADDRESS <b>9640 Mason ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>ROBERT L. LEON</b> First Middle Last 4 DATE OF DEATH <b>May 5</b> Month Day Year <b>14</b> , 19 <b>66</b>		5 SEX <b>M</b> 6 COLOR OR RACE <b>W</b> 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH <b>10/13/34</b> 9. AGE (In years last birthday) <b>31</b> yrs IF UNDER 1 YEAR Months Days Hours Min <b>14</b> <b>19</b> <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>accountant</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Dealer</b> 11. BIRTHPLACE (State or foreign country) <b>Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Cecil Leon</b> 14. MOTHER'S MAIDEN NAME <b>Mary Santucci</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>Korean</b> 16. SOCIAL SECURITY NO. <b>214-30-4411</b> 17. INFORMANT <b>Family records</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Coronary artery disease</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>undet.</b> <b>undet.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>John C. Hyle</b> MD EXAMINER'S NAME (Type) <b>JOHN C. HYLE</b> 22. DATE SIGNED <b>5-16-66</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>5/17/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Balto National Cem</b> 23d. LOCATION (City or Town) (County) (State) <b>Balto Md.</b> 24. FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON 8802 Harford rd.</b> ADDRESS 25a. REC'D BY REGISTRAR <b>MAY 17 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



## CERTIFICATE OF DEATH

06577

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN TB <b>35 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		d. STREET ADDRESS <b>1950 BELAIR ROAD</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>HENRY</b> Last <b>LEWIS</b>		4 DATE OF DEATH Month <b>MAY</b> Day <b>5</b> Year <b>1966</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>APRIL 4, 1925</b>
9. AGE (In years last birthday) yrs <b>41</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>MADISON CO., MISS.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALBERT LEWIS</b>		14. MOTHER'S MAIDEN NAME <b>ORA WALKER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES NW-11</b>		16. SOCIAL SECURITY NO <b>429 24 1513</b>	
17. INFORMANT <b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: <b>163X</b> IMMEDIATE CAUSE (a) <b>CARCINOMA RIGHT LUNG WITH ORIGINAL AND DISTANT METASTASES</b> DUE TO (b) <b>PULMONARY EDEMA</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b> <b>IMMEDIATE</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Mar. 31 4-11-66</b> , to <b>May 5 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 5 1966</b> , and that death occurred at <b>p. M.</b> , from causes and on the date stated above			
22a. SIGNATURE <b>HARON M. QAZI, M.D.</b>		22b. DATE SIGNED <b>5/7/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>HARON M. QAZI, M.D.</b>		22d. ADDRESS <b>V.A. HOSPITAL FORT HOWARD MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-11-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>MARSHALL W. JONES FUN HOME</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 10 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNG. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph</u>		d. STREET ADDRESS <u>9921 Harford Road</u>	
3. NAME OF DECEASED (Type or print) <u>Paul J. Lomonico</u>		4. DATE OF DEATH <u>May 1 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-22-01</u>
9. AGE (in years last birthday) <u>65 yrs.</u>		IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furniture Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mariano Lomonico</u>		14. MOTHER'S MAIDEN NAME <u>Carmala DeVito</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216018294</u>	
17. INFORMANT <u>Magdalen Lomonico</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO (b) <u>Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles H. Donnell</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles H. Donnell</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-5-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25. REC'D BY REGISTRAR <u>MAY 3 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE	





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<div>1</div> <div>26583</div> <div>26579</div>											
<div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div>											
<div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Baltimore County</div> <div>MARYLAND</div>						<div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE</div> <div>MARYLAND</div> <div>b. COUNTY</div> <div>Howard Co</div>					
<div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Mount Wilson</div>				<div>c. LENGTH OF STAY IN 1b</div> <div>9 days</div>		<div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>WOODBINE</div>				<div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>	
<div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Mount Wilson State Hospital</div>						<div>d. STREET ADDRESS</div> <div>Box 42</div>					
<div>3. NAME OF DECEASED (Type or print)</div> <div>First</div> <div>CONSTANCE</div> <div>Middle</div> <div>ANNE</div> <div>Last</div> <div>LOONEY</div>						<div>4. DATE OF DEATH</div> <div>Month</div> <div>MAY</div> <div>Day</div> <div>5</div> <div>Year</div> <div>1966</div>					
<div>5. SEX</div> <div>FEMALE</div>		<div>6. COLOR OR RACE</div> <div>WHITE</div>		<div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>8. DATE OF BIRTH</div> <div>SEPT 6 1933</div>		<div>9. AGE (In years last birthday)</div> <div>32 yrs.</div>		<div>IF UNDER 1 YEAR</div> <div>Months</div> <div>Days</div> <div>Hours</div> <div>Min.</div>	
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>HOUSEWIFE</div>				<div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>OWN HOME</div>		<div>11. BIRTHPLACE (County &amp; State, or foreign country)</div> <div>NEW YORK</div>			<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div>		
<div>13. FATHER'S NAME</div> <div>EDWARD GAPIŃSKI</div>						<div>14. MOTHER'S MAIDEN NAME</div> <div>ELIZABETH MCCORMICK</div>					
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>NO</div>				<div>16. SOCIAL SECURITY NO.</div> <div>217-26657</div>		<div>17. INFORMANT</div> <div>Hosp. records, Mt. Wilson State Hospital</div>					
<div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>PULMONARY TUBERCULOSIS</div> <div>2021</div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</div> <div>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>20c. TIME OF INJURY Month, Day, Year</div> <div>Hour a.m.</div> <div>p.m.</div> <div>19</div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>20f. (City or town) (County) (State)</div> <div>21. I certify that (I) (this hospital) attended the deceased from 4/26, 1966, to 5/5, 1966, that (I) (we) last saw the deceased alive on 5/5, 1966, and that death occurred at 10 AM, from the causes and on the date stated above.</div> <div>22a. SIGNATURE</div> <div>Wm. Newcomer, M.D., Superintendent</div> <div>22b. DATE SIGNED</div> <div>5/5/66</div> <div>22c. PHYSICIAN'S NAME (Type)</div> <div>Wm. Newcomer, M.D., Superintendent</div> <div>22d. ADDRESS</div> <div>Mount Wilson, Maryland</div> <div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> <div>23b. DATE THEREOF</div> <div>5/9/66</div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Holy Redeemer Cemetery</div> <div>23d. LOCATION (City, town or county) (State)</div> <div>Baltimore, Md.</div> <div>24. FUNERAL DIRECTOR</div> <div>Schimunek Funeral Home, Inc.</div> <div>25a. REC'D BY REGISTRAR</div> <div>MAY 12 1966</div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> c. LENGTH OF STAY IN 1b <b>25-days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2114 Maryland Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Linda</b> Middle <b>Diane</b> Last <b>MABOE</b>			4. DATE OF DEATH Month <b>5</b> Day <b>15</b> Year <b>19 66</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 10, 1951</b>		9. AGE (in years last birthday) <b>15</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Luteman</b>					14. MOTHER'S MAIDEN NAME <b>STANTON, Genevieve</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT Address <b>Rosewood Records, Owings Mills, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomembraneous colitis and ileitis, severe.</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/10/66</b> , 19 <b>66</b> , to <b>5/15/66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/15/</b> 19 <b>66</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Harry G. Butler</b> M.D.								22b. DATE SIGNED <b>5/19/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harry G. Butler, M.D.</b>						22d. ADDRESS <b>Rosewood State Hosp., Owings Mills, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/20/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Owings Mills, Md.</b>			
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons Reisterstown, Md.</b>						25a. REC'D BY REGISTRAR <b>MAY 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Balto.</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore #12</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>159 Dumbarton Road</b>					d. STREET ADDRESS <b>159 Dumbarton Road</b>				
3. NAME OF DECEASED (Type or print) <b>FRANCIS M. MACKIN</b>					4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 29, 1910.</b>		9. AGE (In years last birthday) <b>56</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Rept.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Mackin</b>					14. MOTHER'S MAIDEN NAME <b>Sarah McKay</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-03-9728</b>		17. INFORMANT <b>Mrs. Catherine M. Mackin</b>			Address (Same)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO (b) <b>A.S.C.U.D.</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>POLYNEUROPATHY - ETIOLOGY UNDET.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 WKS.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) this hospital attended the deceased from <b>Oct 19 1962</b> to <b>5/21/66</b> , that (2) we last saw the deceased alive on <b>5/21/66</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Donald O Wood MD</b>					22b. DATE SIGNED <b>5/23/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>DONALD O. WOOD MD</b>					22d. ADDRESS <b>TIMONIUM, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/24/66.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>					25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

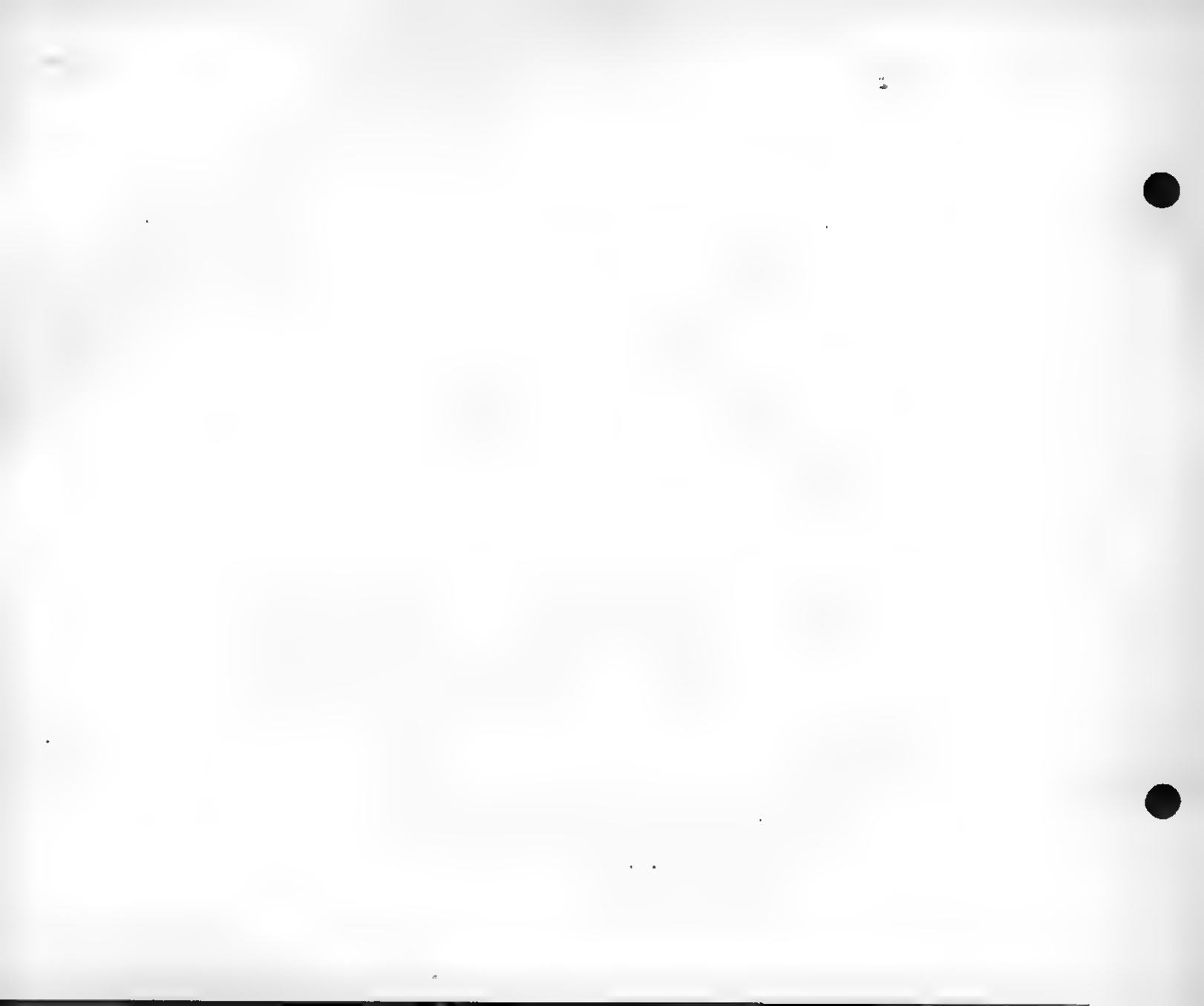
VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06582

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b> c. LENGTH OF STAY IN Tb --- d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		2 USUAL RESIDENCE (Where deceased lived) a. STATE <b>Maryland</b> b. COUNTY --- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1729 E. Baltimore St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Francis B. Magner</b>		4. DATE OF DEATH Month <b>5</b> Day <b>19</b> Year <b>1966</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>April 16, 1919</b>
9 AGE (In years lost birthday) <b>47</b> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>Carnival</b>		11 BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>Lawrence Magner</b>	
14 MOTHER'S MAIDEN NAME <b>Alice L. ---</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>	
16 SOCIAL SECURITY NO <b>5-14-0068</b>		17 INFORMANT <b>Francis B. Magner 2205 Nelson St. Richmond Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. <b>9144</b> IMMEDIATE CAUSE (a) <b>Electrocution</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>standing on wet ground while changing a light bulb</b>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>standing on wet ground while changing a light bulb</b>		20c TIME OF INJURY Month, Day, Year <b>11:20 AM 5 19 1966</b>	
20d INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>field</b>	
20f (City or town) <b>Balto.-rural</b>		20g (County) (State) <b>Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		22. DATE SIGNED <b>5/20/66</b>	
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>5/26/66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem</b>	23d LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24 FUNERAL DIRECTOR <b>William E. Johnson</b>		25a REC'D BY REGISTRAR <b>MAY 24 1966</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>55 Masturtium Lane</u>		d. STREET ADDRESS <u>55 Masturtium Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>F.</u> Last <u>MARINE</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 19-1902</u>
9. AGE (In years last birthday) <u>63</u> yrs		10. F UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth Steel Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Marine</u>		14. MOTHER'S MAIDEN NAME <u>Ella Windsor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>217-01-2807</u>	
17. INFORMANT <u>Muriel Marine (Wife)</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident -</u> + 200 DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Theo. C. Patterson</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>THEO. C. PATTERSON</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>  </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May-6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holly-Hill Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Balto Co. Md.</u>
24. FUNERAL DIRECTOR <u>Connolly Sons - 300 Nure Ave.</u>		25a. REC'D BY REGISTRAR <u>MAY 4 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



VR A15 (4)  
15M 4-64

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall</b>		c. LENGTH OF STAY IN 1b <b>16 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 24 East Joppa Rd.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall</b>	
3. NAME OF DECEASED (Type or print) <b>Wilbur S. Markland Sr.</b>		d. STREET ADDRESS <b>Box 24 East Joppa Road</b>	
5. SEX <b>M</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1966</b>	
6. COLOR OR RACE <b>W</b>		8. DATE OF BIRTH <b>12-9-1883</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>82 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor</b>		11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>C&amp;P Telephone Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William T. Markland</b>		14. MOTHER'S MAIDEN NAME <b>Rachel J. Green</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-03-6006</b>	
17. INFORMANT <b>Arthur Markland</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebral Ischemia, severe</b> <b>4500</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) <b>Generalized Arteriosclerosis, Severe</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute enteritis, non specific</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>10 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 2, 1959</b> to <b>May 22, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 21, 1966</b> , and that death occurred at <b>11A</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Theodore E. Evans</b>		22b. DATE SIGNED <b>DST</b>	
22c. PHYSICIAN'S NAME (Type) <b>Theodore E. Evans, M.D.</b>		22d. ADDRESS <b>9660 Belair Road-Balto. Md. 21236</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-25-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Charles F. Evans &amp; Son 8802 Harford Rd.</b>		25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 06585

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bent Nursing Home Reisterstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Vernon</u> Middle <u>Kemp</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3, 1900</u>
9. AGE (In years last birthday) yrs. <u>66</u>		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Interior Decorator, Balto. Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Martin</u>		14. MOTHER'S MAIDEN NAME <u>Susie Kemp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-16-6313</u>	
17. INFORMANT <u>Frances A. Martin-810 N. Fulton Ave.</u>		Address <u>810 N. Fulton Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Brain Syndrome</u>			
DUE TO <u>Alcohol</u>			
(b) <u>  </u>			
DUE TO <u>  </u>			
(c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/6</u> , 19 <u>66</u> , to <u>5/31</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>5/31</u> , 19 <u>66</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>1 Cherry Hill Rd. Reisterstown Md</u> DATE SIGNED <u>5/31/66</u>			
ACTUAL SIGNATURE <u>MARTIN J. FELDMAN</u> M.D.			
PHYSICIAN'S NAME (Type) <u>MARTIN J. FELDMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/4/66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Fr.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nutter Funeral Home</u>		ADDRESS <u>3035 N. North Ave.</u>	
24a. REC'D BY REGISTRAR <u>JUN 1 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



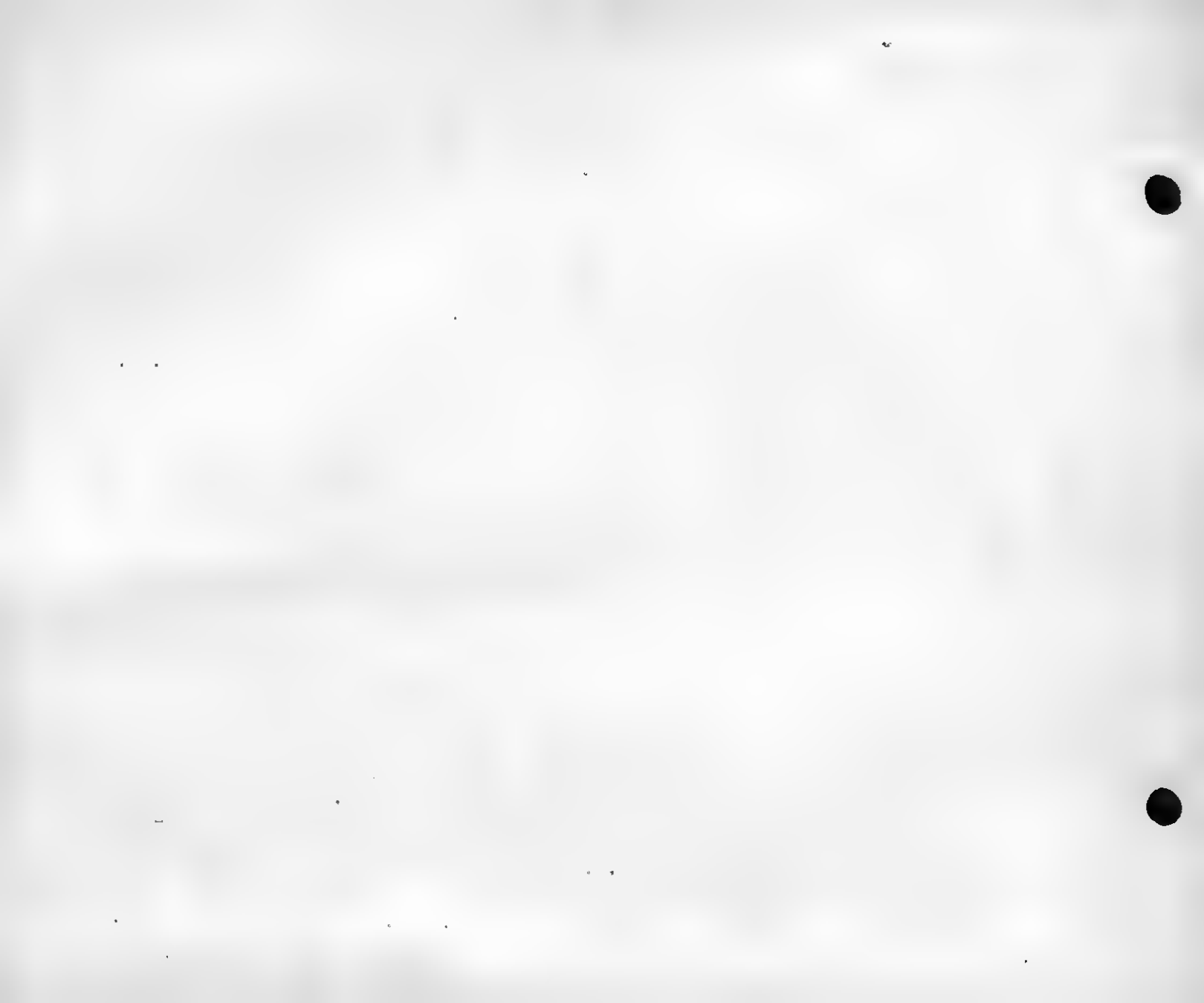
CERTIFICATE OF DEATH

06586

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>5yr3mth9days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>8 Higgins Drive</b>	
3 NAME OF DECEASED (Type or print) <b>Caroline</b>		4 DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>19 66</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 26, 1872</b>
9 AGE (In years birth day) yrs <b>94</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>66</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Parker</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>unknown</b>	
17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO <b>Generalized arteriosclerosis</b> (b) <b>Cerebral vascular accident</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malnutrition and dehydration</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>Jan. 23, 1961</b> to <b>May 4, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 4, 1966</b> , and that death occurred at <b>1:55 P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Stella Wachsler</b>		22b. DATE SIGNED <b>5-4-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/6/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>	23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md.</b>
24. FUNERAL DIRECTOR <b>JOHN F. DENNY, INC. 715 Light St.</b>		25a. REC'D BY REGISTRAR <b>MAY 9 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

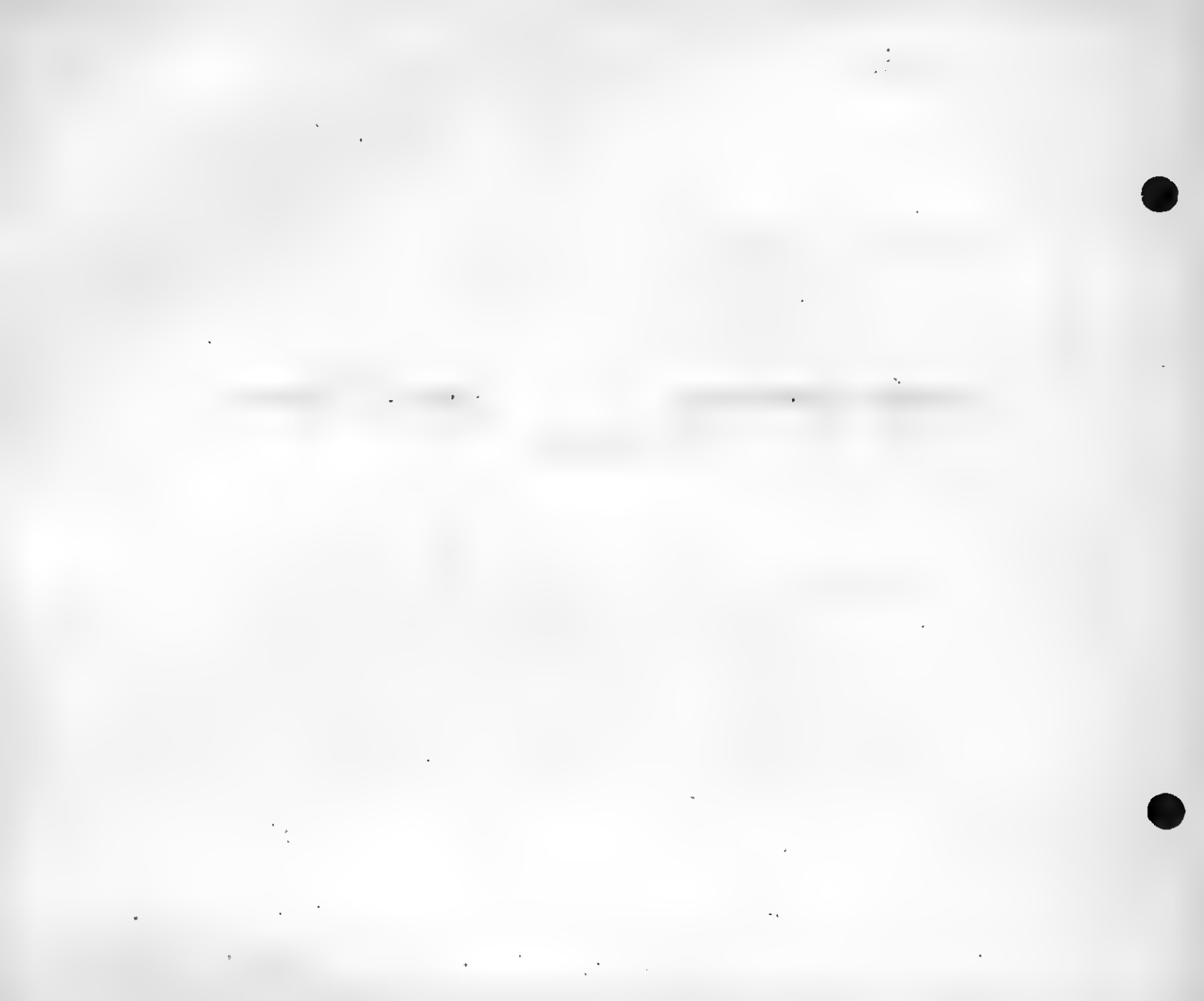




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b <u>1 DAY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>BALTIMORE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>						d. STREET ADDRESS <u>301 CLYDE HILL RD BALTIMORE 1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>NEERA</u> Last <u>McKELOWN</u>			4. DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1966</u>								
5. SEX <u>F</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/10/1917</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>GALLITON PENNSYLVANIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Arthur Hennessy</u>						14. MOTHER'S MAIDEN NAME <u>Harriet Burns</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-20-9221</u>		17. INFORMANT <u>PATIENT'S ADMISSION SHEET</u> Address <u>—</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, BILATERAL</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>10 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11:30 am 5/2, 1966</u> to <u>9:00 pm 5/2, 1966</u> , that (I) (we) last saw the deceased alive on <u>5:00 pm 5/2, 1966</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)						22b. DATE SIGNED <u>5/2/66</u>					
22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>5-5-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home</u>						25a. REC'D BY REGISTRAR <u>MAY 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Towson</u>		c LENGTH OF STAY N 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>		d STREET ADDRESS <u>9 Talbott Avenue</u>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>Homer Dorsey McLean McLean</u>		4 DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-27-82</u>
9 AGE (In years lost birthday) <u>83</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurseryman</u>	10b KIND OF BUSINESS OR INDUSTRY <u>Towson Nurseries</u>
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Arthur McLean</u>		14 MOTHER'S MAIDEN NAME <u>Ruth ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16 SOCIAL SECURITY NO <u>218-18-3577</u>	
17 INFORMANT <u>Family Records</u>		Address	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Sudden</u> (c) <u>Sudden</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m. <u>19</u>	20d INJURY OCCURRED Where at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. Donnell</u>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
23a B. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>May 7, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Memorial Gardens</u>	23d LOCATION (City or town) (County) (State) <u>Cockeysville, Maryland</u>
24 FUNERAL DIRECTOR <u>John Burns Sons</u>		25a REC'D BY REGISTRAR <u>Towson Md.</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
		DATE <u>MAY 10 1966</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

62595

06595

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>7 Yr.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUMMIT CONV. HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>STELLA McLEAN</b>		4. STREET ADDRESS <b>4439 Penn Lucy Rd.</b>	
5. SEX <b>F</b>		6. DATE OF DEATH <b>MAY 20 1966</b>	
7. COLOR OR RACE <b>W</b>		8. DATE OF BIRTH <b>1/18/81</b>	
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (in years last birthday) <b>85</b> yrs.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		12. CITIZEN OF WHAT COUNTRY? <b>ELLICOTT CITY, MD.</b>	
13. FATHER'S NAME <b>JAMES GALLAGHER</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE BAKER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>FRANK SCOTT</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause test. (b) <b>Pneumonia</b> DUE TO <b>Cardiovascular disease, accident fracture right femur</b> DUE TO (c) <b>fracture repaired at St. Agnes Hosp. Pins.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture repaired at St. Agnes Hosp. Pins.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <b>Fell on floor at nursing home</b>	
20c. TIME OF INJURY Month, Day, Year <b>? Hour a.m. p.m. 4-17 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Nursing home</b>		20f. (City or town) (County) (State) <b>Catonville Balto MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>GEO. S. M. KIEFFER M.D.</b>		22. DATE SIGNED <b>MAY 20 1966</b>	
EXAMINER'S NAME (Type) <b>GEO. S. M. KIEFFER M.D.</b>		Address (Street, city, town, or county) <b>1010 Leed on</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/23/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL</b>		23d. LOCATION (City, town or county) (State) <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR <b>F. S. MACNAB</b>		25a. REC'D BY REGISTRAR <b>21238</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>MAY 23 1966</b>	



FOR STATE  
HEALTH DEPT.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06589

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <b>Md.</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c LENGTH OF STAY IN lb <b>8 mos.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4 Straw Hat Rd.</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>McMahan</b> Last <b>McMahan</b>		4 DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>19 66</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Mar. 31, 1882</b>
9 AGE (In years, months, days) <b>84</b> yrs		10 IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Foster Brothers Co.</b>	
11 BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Milton Beck</b>		14 MOTHER'S MAIDEN NAME <b>Emma Smith</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16 SOCIAL SECURITY NO <b>215-10-6939</b>	
17 INFORMANT <b>Mrs. Florence Irwin</b>		Address <b>Mills, Md. 4 Straw Hat Rd., Owings</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>10 min (est)</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>none</b> p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
6 Hanover Rd., Reisterstown, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		22. DATE SIGNED <b>5-18-66</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>May 19, 1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>Hametown Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Hametown, Pennsylvania</b>
24 FUNERAL DIRECTOR <b>Frank H. Newell</b>		25 REC'D BY REGISTRAR <b>MAY 20 1966</b>	
ADDRESS		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space for the signature of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06590

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN b <b>Ex 118</b> d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <b>Beltway - Between Wilkens &amp; Frederick Ave</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Burnie</b> d. STREET ADDRESS <b>113 Bliss Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>RHEINHOLD MEILER, Jr.</b>		4. DATE OF DEATH Month <b>5</b> Day <b>16</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 19, 1947</b>
9 AGE (In years last birthday) yrs <b>18</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Clerk</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>Food Store</b>		11 BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13 FATHER'S NAME <b>Reinhold Meiler Sr.</b>	
14 MOTHER'S MAIDEN NAME <b>Lottie Scheckels</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>217-46-3411</b>		17 INFORMANT <b>Glen Burine, Md.</b> Address <b>Mr. Reinhold Meiler 113 Bliss Lane</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>8124</b> IMMEDIATE CAUSE (a) <b>Crushing injuries of head and chest</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19 WAS AUTOPSY PERFORMED? Par YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury on Part I or Part II of item 18) <b>Pedestrian struck by auto Beltway between Wilken &amp; Frederick</b>	
20c TIME OF INJURY Month, Day, Year Hour o.m. <b>2:48</b> <del>xxxx</del> <b>5-16 1966</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Street</b>		20f. (City or town) (County) <b>Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S Fisher</b> M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED <b>5-16-66</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>May 17, 1966</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Lake View Cem.</b>		23d LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>G. Truman Schwab</b>		25a REC'D BY REGISTRAR <b>MAY 18 1966</b>	
ADDRESS <b>3512 Frederick Ave. Balto. Md.</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



CERTIFICATE OF DEATH

66593

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admn'ssion) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21218</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Armecost Nursing Home</b>		d. STREET ADDRESS <b>606 Wyanoke Ave.</b>	
3 NAME OF DECEASED (Type or print) First <b>Ethel</b> Middle <b>B.</b> Last <b>Melvin</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 66</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/2/1884</b>
9. AGE (In years last birthday) <b>81</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Principle - Retired</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Crisfield, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Francis M. Melvin</b>	
14. MOTHER'S MAIDEN NAME <b>Lucy Ward</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Marion H. Melvin</b> Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4221</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>Apr. 18</b> , 19 <b>66</b> to <b>May 15</b> , 1966, that (I) (we) last saw the deceased alive on <b>May 13</b> , 19 <b>66</b> , and that death occurred at <b>8:15</b> M., from causes and on the date stated above.			
22a. SIGNATURE <i>Lloyd E. Saylor</i> M.D.		22b. DATE SIGNED <b>5-17-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lloyd E. Saylor</b>		22d. ADDRESS <b>3902 Greenmount Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/18/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Balto. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 17 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and up any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06599

06592

1 PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHADY NECK HOME</u>				d. STREET ADDRESS <u>211 SANFORD AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>EVA C. MERSON</u> First Middle Last				4 DATE OF DEATH <u>MAY 22 1966</u> Month Day Year			
5 SEX <u>F</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/8/85</u> 9 AGE (In years last b. day) <u>80</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HARRY C. HERBERT</u>				14. MOTHER'S MAIDEN NAME <u>CAROLINE DEETS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.		17. INFORMANT Address <u>HELEN M. BATZLER</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A.S.C.V. Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Urinary Tract Infection</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1966</u> , to <u>May 22, 1966</u> , that (I) <del>was</del> last saw the deceased alive on <u>May 21, 1966</u> , and that death occurred at <u>12 P.M.</u> , from causes and on the date stated above							
22a. SIGNATURE <u>DeMeeLaughlin</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED <u>5/22/66</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>BURIAL</u>		<u>5/25/66</u>		<u>LEUDON PARK</u>		<u>BALTO. MD.</u>	
24 FUNERAL DIRECTOR <u>MACNABB &amp; SON</u>				25. REC'D BY REGISTRAR DATE <u>MAY 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	
ADDRESS <u>301 FREDERICK</u>							



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06593

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>13 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chase</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>		d. STREET ADDRESS <b>Box 175, Eastern Avenue</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ann</b> Middle <b>Louise</b> Last <b>MESSINGER</b>		4. DATE OF DEATH Month <b>5</b> Day <b>26</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-11-46</b>
9. AGE (in years last birthday) <b>19</b> yrs		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>26</b> Hours <b>19</b> Min <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Chase, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Clifton Francis Messinger</b>	
14. MOTHER'S MAIDEN NAME <b>Edith Eleanor Bonnie</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Bronchitis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Congenital infantile spastic paralysis with symptomatic epilepsy</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 day</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (X) (this hospital) attended the deceased from <b>2-25</b> , 19 <b>53</b> , to <b>5-26</b> , 19 <b>66</b> , that (X) (we) last saw the deceased alive on <b>5-26</b> , 19 <b>66</b> , and that death occurred at <b>9:45</b> <b>home</b> causes on and on the date stated above.	
22a. SIGNATURE <b>Harry G. Butler, M.D.</b>		22b. DATE SIGNED <b>5-26-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harry G. Butler, M.D.</b>		22d. ADDRESS <b>Rosewood Lane, Owings Mills, Maryland</b>	
23a. BURIAL, CREMAT, OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-31-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Lassala Funeral Home, 7401 Belair Rd.</b>		25a. REC'D BY REGISTRAR <b>MAY 31 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN 1b <b>Plant Hospital</b>		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Plant Hospital</b>		e. USUAL RESIDENCE (When deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> COUNTY <b>Baltimore</b> <b>3103 Kenyon Avenue</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>3103 Kenyon Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <b>Herbert</b>		First <b>Herbert</b>		Middle <b>E.</b>		Last <b>Metzger</b>		4. DATE OF DEATH Month <b>5</b> Day <b>26</b> Year <b>1966</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-18-1904 1905</b>		9. AGE (in years last birthday) <b>61 62 yrs.</b>		10. FUNDER 1 YEAR Months <b>6</b> Days <b>2</b> Hours <b>0</b> Min. <b>0</b>		11. FUNDER 24 HRS. Months <b>6</b> Days <b>2</b> Hours <b>0</b> Min. <b>0</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Making</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>															
13. FATHER'S NAME <b>Frederick Metzger</b>								14. MOTHER'S MAIDEN NAME <b>Mary ( Unknown )</b>																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>				17. INFORMANT <b>3103 Kenyon Avenue Mrs Frances C. Metzger</b>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 4201 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____																INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute upper Respiratory Infection</b>																											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> <b>n</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Acute upper Respiratory Infection</b>				20c. TIME OF INJURY Month, Day, Year Hour <b>e.m.</b> <b>19</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>e</b>				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																											
ACTUAL SIGNATURE <b>Theodore Patterson</b>				EXAMINER'S NAME (Type) <b>Theodore Patterson, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED <b>5-26-66</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>5/30/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>				24. FUNERAL DIRECTOR <b>Henry Sander &amp; Sons Inc. Balto. MD.</b>				25a. REC'D BY REGISTRAR <b>MAY 31 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

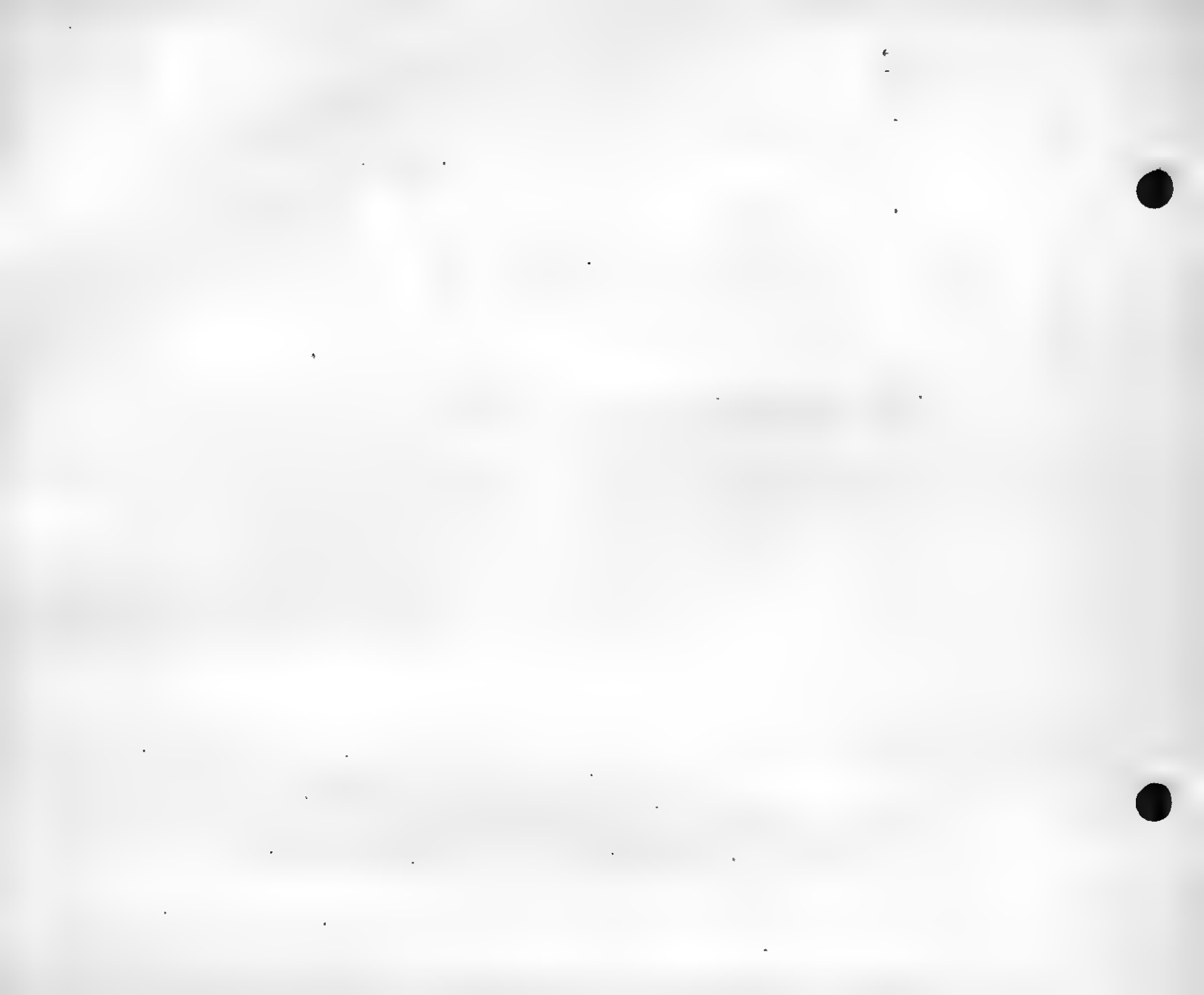
## CERTIFICATE OF DEATH

26602

06596

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>4806 York Road #18</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Allen</b> Middle <b>Lee</b> Last <b>Miller</b>		4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>1966</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 27, 1966</b>		9. AGE (In years last birthday) yrs. <b>1</b> IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>William Robert Miller</b>						14. MOTHER'S MAIDEN NAME <b>Jacqueline McCracken</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> <b>776x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 27, 1966</b> , to <b>May 28, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 28, 1966</b> , and that death occurred at <b>11: M</b> , from the causes and on the date stated above. <b>55P.</b>															
22a. SIGNATURE <b>Nelson S. de la Paz</b>												22b. DATE SIGNED <b>May 29, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Nelson S. de la Paz</b>						22d. ADDRESS <b>7620 York Road, 21204</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6/1/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat'l Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR <b>Robert C. Altenburg - 6009 Harford Rd.</b>						25a. REC'D BY REGISTRAR <b>JUN 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							
Funeral Home, Inc.															

MEDICAL CERTIFICATION



66603

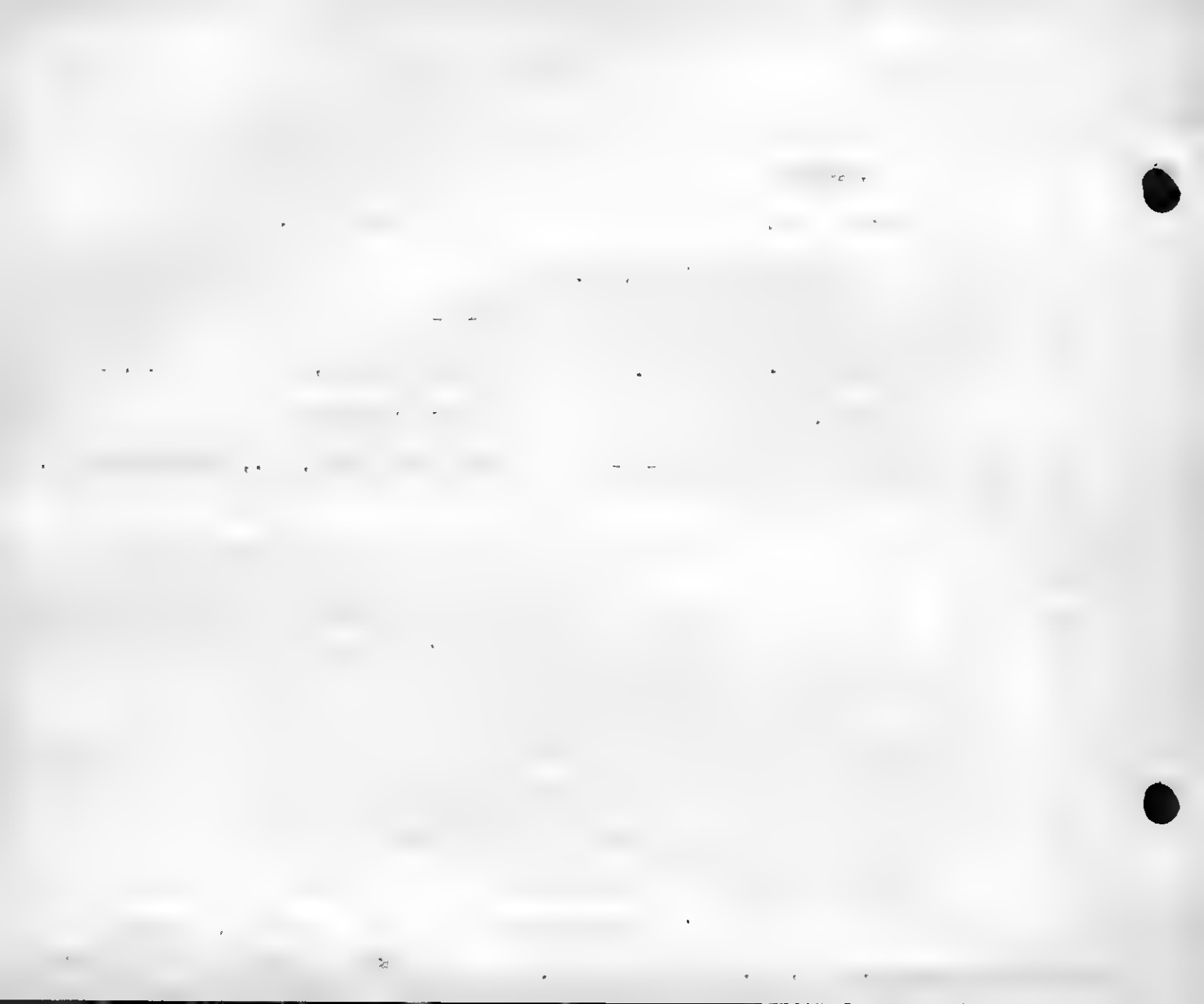
## CERTIFICATE OF DEATH

06597

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glendale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glendale Baltimore #12</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1303 Highland Dr.</b>		d. STREET ADDRESS <b>1303 Highland Dr.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>James Glen Miller, Sr.</b>		4. DATE OF DEATH Month Day Year <b>5-26-66</b> 19	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-30-99</b>
9. AGE (In years last birthday) yrs. <b>67</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>South Hampton, Ontario</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>William L. Miller</b>		14 MOTHER'S MAIDEN NAME <b>Margaret Combs</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>578-05-1288</b>	
17. INFORMANT <b>James Glen Miller, Jr.</b>		Address <b>1303 Highland Dr.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4200</b> DUE TO <b>Coronary failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Left ventricular failure (50%) for cardiac filling</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5+2/2</b>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 23, 1966</b> to <b>May 26, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 24, 1966</b> , and that death occurred at <b>4:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Frederick J. Vollmer</b>		22b. DATE SIGNED <b>5-27-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>FREDERICK J. VOLLMER</b>		22d. ADDRESS <b>4110 YORK RD. BALTIMORE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/30/66.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. 5305 Harford Rd.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 27 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
26804					CERTIFICATE OF DEATH					06598					
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>					c. LENGTH OF STAY IN 1b <b>3 1/2 yrs.</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 811 S. 50 th Street</b>					d. STREET ADDRESS <b>811 S. 50 th Street 21222</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>MATILDA</b> Middle <b>MILLER</b> Last <b>MILLER</b>					4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 66</b>										
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 10- 1891</b>		9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>					
13. FATHER'S NAME <b>Casimir Rutkowski</b>					14. MOTHER'S MAIDEN NAME <b>Frances Prock</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>214-38-1113</b>					17. INFORMANT <b>Daughter, Mrs. Catherine Barr, # 2, a, b, c, d.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerotic (A. V. Disease)</b> (c) <b>Diabetes Mellitus</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>5 yrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <b>1965 to May 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 25, 1966</b> , and that death occurred at <b>12:48 PM</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>Stephen C. Mackowiak</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22b. DATE SIGNED <b>May 27-1966</b>					
22c. PHYSICIAN'S NAME (Type) <b>Stephen C. Mackowiak M.D.</b>										22d. ADDRESS <b>6714 Holabird Ave. Balto. Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>May 30-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>			23d. LOCATION (City, town or county) (State) <b>Dundalk, Maryland 21222</b>							
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>										25a. REC'D BY REGISTRAR <b>JUN 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Duda</b>			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

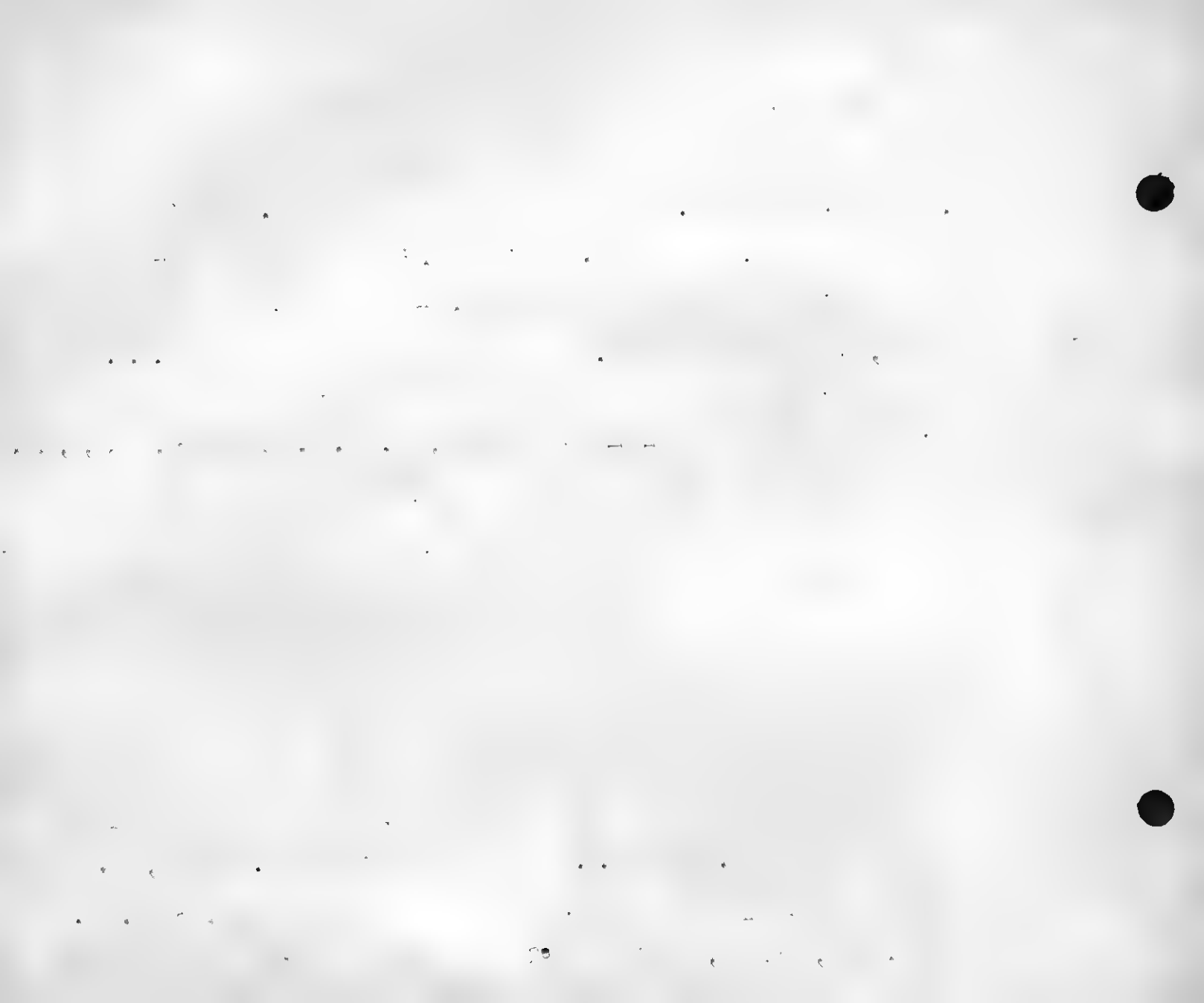
1 PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst. put on Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>BALTO.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Upperco.</i>		c. LENGTH OF STAY IN 1b <i>3 mos</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Parrih Rd.</i>		d. STREET ADDRESS <i>SPRINGFIELD STATE HAVEN</i>	
3 NAME OF DECEASED (Type or print) <i>PEARL ESTELLA MILLER</i>		4 DATE OF DEATH <i>May 10 1966</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W-DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>May 15, 1924</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Canning Factory</i>	9 AGE (In years last birthday) <i>41 yrs</i>
11 BIRTH-PLACE (State or foreign country) <i>Md.</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13 FATHER'S NAME <i>Howard Brnbl.</i>		14 MOTHER'S MAIDEN NAME <i>Ellen A. Cullinan</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No.</i>		16 SOCIAL SECURITY NO. <i>218281637</i>	
17 INFORMANT <i>Ann Engle</i>		Address <i>Upperco, Md.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4201</i> DUE TO <i>Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>7 hrs</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>none</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none</i>	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>D. D. Caples</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) _____	
22. DATE SIGNED <i>5-10-66</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5/13/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Grace Methodist</i>	23d. LOCATION (City or Town) _____ (County) _____ (State) _____
24. FUNERAL DIRECTOR <i>J. F. Eline &amp; Sons</i>		ADDRESS <i>Reisterstown, Md.</i>	
25a. REC'D BY REGISTRAR <i>MAY 16 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

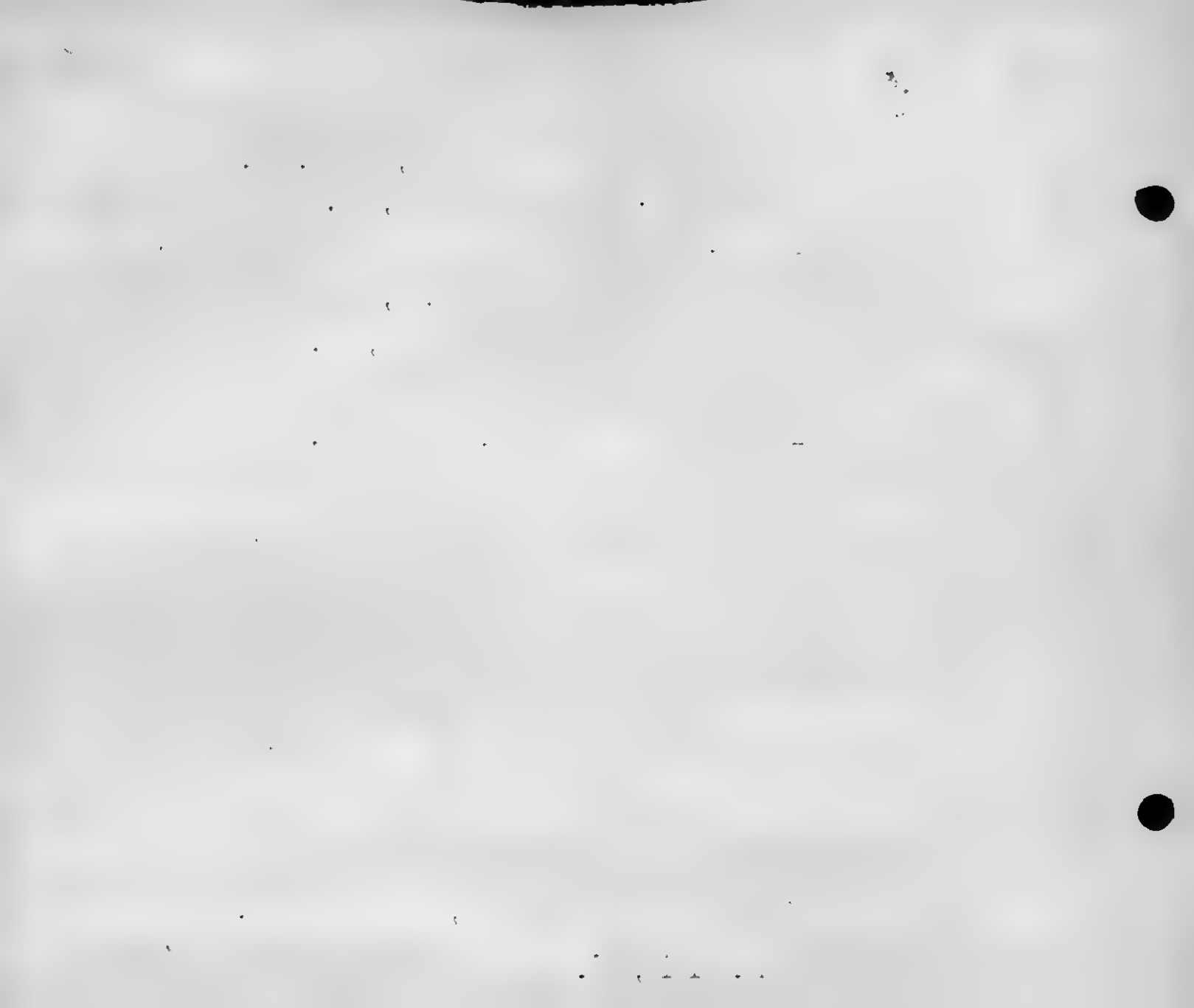
<div> <div>1</div> <div> <div>66606</div> <div>06600</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div>																	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>9 months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Res. 8015 Gray Haven Rd.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>8015 Gray Haven Rd. 21222</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>ALMA</b> Middle <b>A.</b> Last <b>MONTGOMERY</b>			4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>19 66</b>			5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					
8. DATE OF BIRTH <b>Aug. 1- 1883</b>			9. AGE (In years last birthday) <b>82</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Maryland Casualty Co.</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>					
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>						13. FATHER'S NAME <b>George Sumwalt</b>						14. MOTHER'S MAIDEN NAME <b>Ella J. Sumwalt</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. (If yes give year or dates of service) <b>212-10-3162</b>			17. INFORMANT <b>Grandson, Mr. Wm. H. Montgomery, #2, a, b, c, d.</b>			Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the transverse Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized metastasis</b> (c) <b>Generalized arteriosclerosis</b>												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>6-2</b> , 19 <b>65</b> to <b>5-9</b> , 19 <b>66</b> , that (I) <del>last</del> saw the deceased alive on <b>5-3</b> , 19 <b>66</b> , and that death occurred at <b>10 A</b> M, from the causes and on the date stated above.																	
22a. SIGNATURE <b>Eugene F. Nevy</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>May 3-1966</b>							
22c. PHYSICIAN'S NAME (Type) <b>Eugene F. Nevy M.D.</b>						22d. ADDRESS <b>7001 Mornington Rd. Dundalk, Md. 21222</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>May 5-1966</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>			23d. LOCATION (City, town or county) (State) <b>Ritchie Hwy. Balto. Md. 25</b>								
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>						25a. REC'D BY REGISTRAR <b>MAY 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (5)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY in life <b>life</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON, Balto., Co. Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>ELSIE M. MOORE</b>		First		Middle		Last		4. DATE OF DEATH <b>May 21st, 1966</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 2, 1885</b>		9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Henry Kuauss</b>				14. MOTHER'S MAIDEN NAME <b>Annie Winters</b>				17. INFORMANT <b>Pres. Home of Md.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/degrees of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>-</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL ARTERIOSCLEROSIS</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Yrs</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>BALTO.</b>		(County) <b>BALTO.</b>		(State) <b>MARYLAND</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>JAN 1958</b> to <b>MAY 21, 1966</b> , that (I) (we) last saw the deceased alive on <b>MAY 18, 1966</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Mitchell Wiedefeld</b>						22b. DATE SIGNED <b>MAY 24, 66</b>		22c. PHYSICIAN'S NAME (Type) <b>S J. VENABLE JR M.D.</b>		22d. ADDRESS <b>7215 YORK RD BALTIMORE MD 21212</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/23/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem</b>		23d. LOCATION (City, town or county) <b>Balto.</b>		(State) <b>Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Mitchell-Wiedefeld Home, Inc.</b>						ADDRESS <b>6500 York Rd. 21212, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

26608

06602

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN b <u>6 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stella Maris Hospice</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>1301 Roland Ave.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Margaret Cecilia Moore</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>5</u> <u>4</u> <u>19</u> <u>66</u> Month Day Year							
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9/30/1870</u>		<b>9. AGE</b> (In years last birthday) <u>95</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Harrisburg, Pa.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>William Heaps</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ellen Swartz</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>213-50-7215</u>				<b>17. INFORMANT</b> <u>Edwin A. Moore</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 4221 DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)										<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>3/22/66</u> , 19 <u>66</u> , to <u>5/1/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/22/66</u> , 19 <u>66</u> , and that death occurred at <u>2:10 PM</u> from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>Frank J. Kuehn</u> M.D.						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>5/4/66</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Frank Kuehn</u>						<b>22d. ADDRESS</b> <u>Medical Arts Bldg., Cathedral</u>					
<b>23a. BURIAL, CREMATION, REMOVAL.</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>5/7/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Balto. Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Balto., Md.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>L. J. Buck (Per RCV)</u>						<b>ADDRESS</b> <u>Balto.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAY 9 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





## CERTIFICATE OF DEATH

CC603

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> = b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Batonsville</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>8309 Fourteenth Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Oliver</b> Middle <b>N.</b> Last <b>Moreland</b>		4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1895</b>
9. AGE (In years last birthday) yrs. <b>70</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>UNKNOWN WATCHMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BAKERY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>LAUREL MARYLAND</b> <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>UNKNOWN NEHIMAH NATHANIEL</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN ROSE FLOWER.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Army 1919</b>		16. SOCIAL SECURITY NO <b>579-22-1199</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)		INTERVA. BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 11, 1966</b> , to <b>May 21, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 21, 1966</b> , and that death occurred at <b>8:00</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b>		22b. DATE SIGNED <b>5-23-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b> <b>Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>May 26, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>
24. FUNERAL DIRECTOR <b>Arthur Waters 254 Carter St. NE, Wash. D.C. 20002</b>		25a. REC'D BY REGISTRAR <b>MAY 27 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



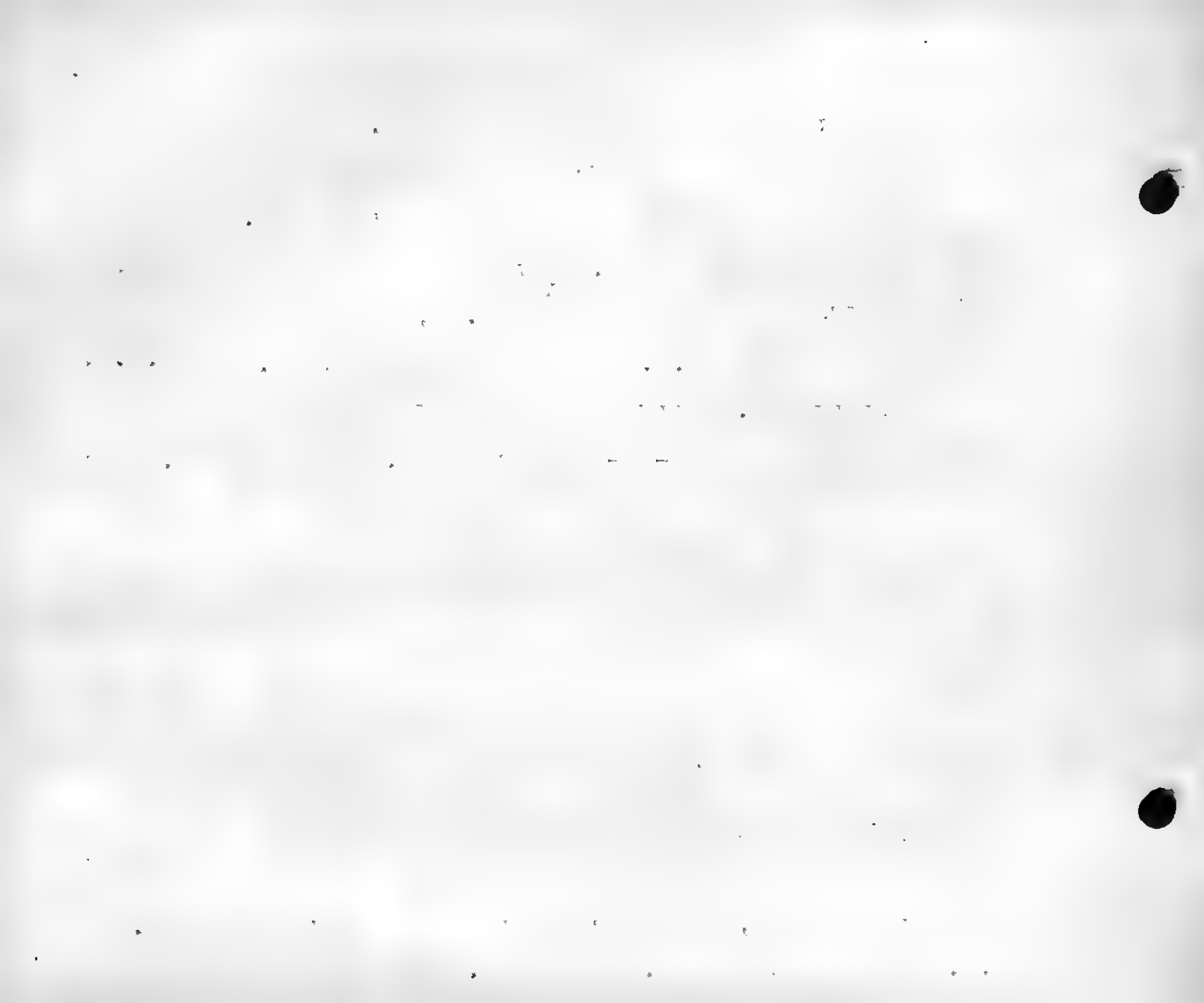
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MD.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN ID <b>6 WKS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>STELLA MARIS HOSPICE</b>		d. STREET ADDRESS <b>4301 ROLAND AVE.</b>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH G. MULLEN</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>7</b> Year <b>19 66</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 20, 1878</b>
9a. AGE (In years last birthday) <b>87 yrs.</b>		9b. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.N.</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM F. MULLEN</b>		14. MOTHER'S MAIDEN NAME <b>ALICE HANAWAY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>213-48-9318</b>	
17. INFORMANT <b>MILTON G. ZEILER</b>		Address <b>2905 N. CHARLES ST</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Fracture of Skull</b> <b>4047</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from loose metal Scaffolding Fractured Skull</b>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>5:15</b> p.m. <b>5/7/66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home (Nursing Home)</b>		20f. (City or town) (County) (State) <b>Towson Baltimore</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>5/7/66</b>	
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 10, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MD.</b>	
24. FUNERAL DIRECTOR <b>H.W. MEARS &amp; SON</b>		25a. REC'D BY REGISTRAR <b>MAY 11 1966</b>	
Address <b>805 N. CALVERT ST.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14  
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06611											
06605											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN It <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOUSE IN PINES</u>						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>208 S. LONDON AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>T.</u> Last <u>MURPHY</u>						4. DATE OF DEATH Month <u>MAY</u> Day <u>11</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 27, 1886</u>		9. AGE (in years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>FRANK P. PHILBIN</u>						14. MOTHER'S MAIDEN NAME <u>MARY ELLEN WELSH</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO. <u>---</u>					
17. INFORMANT <u>Laura M. Murphy - 208 S. London Ave</u>						Address <u>---</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Stomach and Intestinal</u> DUE TO <u>3 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular atherosclerosis</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>---</u> p.m. <u>---</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u> 20f. (City or town) <u>---</u> (County) <u>---</u> (State) <u>---</u>											
21. I certify that (I) (this hospital) attended the deceased from <u>May 10, 1966</u> to <u>May 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 10, 1966</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>J. Nelson</u> M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>May 11, 1966</u>					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS <u>---</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-14-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Landon-Corham</u>				23d. LOCATION (City, town or county) <u>Beth.</u> (State) <u>Ind.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John C. ...</u>						25a. REC'D BY REGISTRAR <u>MAY 13 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 06606

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE COUNTY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6904 BELLONA AVE</b>		d. STREET ADDRESS <b>6904 BELLONA AVE</b>	
3. NAME OF DECEASED (Type or print) First <b>PHILIP</b> Middle <b>J.</b> Last <b>MUTH</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 8, 1908</b>
9. AGE (In years last birthday) yrs. <b>57</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PARTNER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MUTH BROTHERS</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>CHARLES P. MUTH</b>		14. MOTHER'S MAIDEN NAME <b>MARY BELLE ELLINGER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>PHILIP J. MUTH, JR 206 OAKDALE RD</b>	
17. INFORMANT <b>PHILIP J. MUTH, JR 206 OAKDALE RD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 4+01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr 19, 1966</b> to <b>May 28, 1966</b> , that I last saw the deceased alive on <b>May 1, 1966</b> , and that death occurred at <b>12:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frederick J. Vollmer</b>		ADDRESS (Street, city or town, state) <b>6100 York Rd Baltimore, Md 21212</b>	
PHYSICIAN'S NAME (Type) <b>FREDERICK J. VOLLMER</b>		DATE SIGNED <b>5/29/66</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/31/66</b>	22c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. W. MEARS &amp; SON 805 N. CALVERT ST</b>		24. REGISTAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06618					06607				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c. LENGTH OF STAY IN 1b <u>3 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			d. STREET ADDRESS <u>4109 Norfolk Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Milford Manor Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>S.</u> Last <u>Nathanson</u>					4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>19 66</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Eli Steinbach</u>					14. MOTHER'S MAIDEN NAME <u>Hinda ?</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Henry Nathanson 4505 Penhurst Avenue</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASCVD, c Congestive Ht. Failure</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>5/23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/23</u> 19 <u>66</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>M. J. Ellin</u>					22b. DATE SIGNED <u>5/23/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Dr. Morton J. Ellin</u>					22d. ADDRESS <u>8629 Liberty Road</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>5/24/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beth Tfilohm</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. 6010 Reisterstown Road</u>					25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>				
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06614

06608

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE COUNTY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Louison - 4</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>BALTIMORE COUNTY GENERAL</b>		d. STREET ADDRESS <b>2116 St. Lukes La</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>EDGAR</b> Last <b>NEEB</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>29</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-18-1900</b>
9. AGE (in years last birthday) <b>66</b> yes		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLUMBER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF</b>	
11. BIRTHPLACE (County & State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE F. NEEB</b>		14. MOTHER'S MAIDEN NAME <b>SKIPP</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>212-26 9828</b>	
17. INFORMANT <b>Mrs. ANNA NEEB</b>		Address <b>2116 ST. LUKES</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>dehydration &amp; hypertension</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour o m p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/21</b> , 19 <b>66</b> , to <b>5/29</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/29</b> , 19 <b>66</b> , and that death occurred at <b>12:00</b> AM, from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>5/29/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>AMABLE MENDOZA, M.D.</b>		22d. ADDRESS <b>Balto. County Gen. Hosp.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>6-1-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>	23d. LOCATION (City or Town) (County) (State) <b>WOODLAWN, BALTO. MD</b>
24. FUNERAL DIRECTOR <b>JOHN T. STANSBURY</b>		25a. REC'D BY REGISTRAR <b>JUN 1 1966</b>	
ADDRESS <b>6411 WINDSOR MILL ROAD</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



VR A15 (4)  
15M 4-64

23

## MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
06615																			
06609																			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown, Md.</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County Gen. Hosp.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>608 Carysbrook Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Lola</u> Last <u>Nelson</u>					4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1966</u>														
5. SEX <u>FEMALE</u>					6. COLOR OR RACE <u>WHITE</u>					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH <u>5-18-88</u>					9. AGE (In years last birthday) <u>78</u> yrs.					10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR TO 24 HRS. <input type="checkbox"/> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>B.V.D. Corp.</u>					11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>									
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					13. FATHER'S NAME <u>DANIEL WILLIAMS</u>					14. MOTHER'S MAIDEN NAME <u>LAURA VIRGINIA DEEMS</u>									
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>712-10-4857</u>					17. INFORMANT Address <u>Pikesville 8, Md.</u> <u>Mrs. Laura V. Sanford, 608 Carysbrook Rd.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>  </u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>									
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>					20f. (City or town) (County) (State) <u>  </u>									
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1966</u> to <u>May 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 4, 1966</u> , and that death occurred at <u>12:40</u> M, from the causes and on the date stated above.										22a. SIGNATURE <u>B. Alonso</u>					22b. DATE SIGNED <u>  </u>				
22c. PHYSICIAN'S NAME (Type) <u>B. ALONSO</u>					22d. ADDRESS <u>  </u>					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>May 6, 1966</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Park Cemetery</u>									
23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>					24. FUNERAL DIRECTOR <u>Frank H. Stewy, Pikesville 8, Md.</u>					25a. REC'D BY REGISTRAR <u>  </u>									
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					25c. DATE <u>MAY 12 1966</u>					25d. <u>  </u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>Towson</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>21212</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1116 Overbrook Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>P. Charles</b> Middle <b>Nelson</b> Last <b>Nelson</b>			4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>19 66</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-3-03</b>		9. AGE (In years last birthday) <b>63</b> yrs. IF UNDER 1 YEAR: Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min. <b>63</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-Warehouse</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Sears-Roebuck</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Charles Nelson</b>					14. MOTHER'S MAIDEN NAME <b>Mary Vanik</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>219-10-7359</b>		17. INFORMANT <b>Mrs. Eleanor G. Nelson</b> Address <b>(Same)</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal aneurysm</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May 7, 19 66</b> to <b>May 19, 19 66</b> , that (I) (we) last saw the deceased alive on <b>May 19, 19 66</b> , and that death occurred at <b>5:05A</b> AM, from the causes and on the date stated above.									
22a. SIGNATURE <b>Rostom D. Rivera</b>					22b. DATE SIGNED <b>May 19, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Rostom D. Rivera</b>		
					22d. ADDRESS <b>7620 York Road 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>5/21/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION (City, town or county) (State) <b>Woodlawn, Balto. Co., Md.</b>		
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Baltimore 12, Md.</b>					25a. REC'D BY REGISTRAR <b>MAY 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MAY 24 1966											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Manor Nursing Home</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Wilmington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2100 Alex Rd.</b> d. STREET ADDRESS <b>2100 Alex Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna A. Neubauer</b>						4. DATE OF DEATH Month Day Year <b>May 22 1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 31, 1891</b>		9. AGE (In years last birthday) <b>74 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>74 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George Prager</b>						14. MOTHER'S MAIDEN NAME <b>Emilie S. Adelung</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-10-7195</b>		17. INFORMANT <b>Mr. George L. Doetsch</b> Address <b>1500 Stonewood Rd. 12</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1621 Atelectatic Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchogenic Carcinoma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive Heart Failure</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>3 mos. (max)</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <b>August 1965</b> to <b>May 22, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 19, 1966</b> , and that death occurred at <b>1:02 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert B. Bradley</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/24/66</b>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>5/25/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorriane Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202</b>						25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
066113					CERTIFICATE OF DEATH					06612				
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN b <b>48 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Chesapeake Manor Nursing Home Joppa Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>110 Dumbarton Road - 32</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Paula</b> Middle <b>Cecelia</b> Last <b>Owings</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>11</b> Year <b>1966</b>											
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>II/16/80</b>		9. AGE (in years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY?						
13. FATHER'S NAME <b>Henry Niemann</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Tuer</b>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family - Same</b>			Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>GENERALIZED ARTEROSCLEROSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>RHEUMATIC HEART DISEASE</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) <del>this hospital</del> attended the deceased from <b>APRIL 10, 1966</b> to <b>MAY 11, 1966</b> , that (I) <del>last</del> saw the deceased alive on <b>MAY 9, 1966</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>John M. Scott</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <b>John M. Scott, M. D.</b>			22b. DATE SIGNED <b>MAY 11, 1966</b>						
22c. PHYSICIAN'S NAME <b>John M. Scott, M. D.</b>					22d. ADDRESS <b>600 W. Belvedere Ave - 21210</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>			23b. DATE THEREOF <b>5/13/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore</b>						
24. FUNERAL DIRECTOR <b>McCully - 130 E. Fort Ave.</b>					25a. REC'D BY REGISTRAR <b>MAY 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



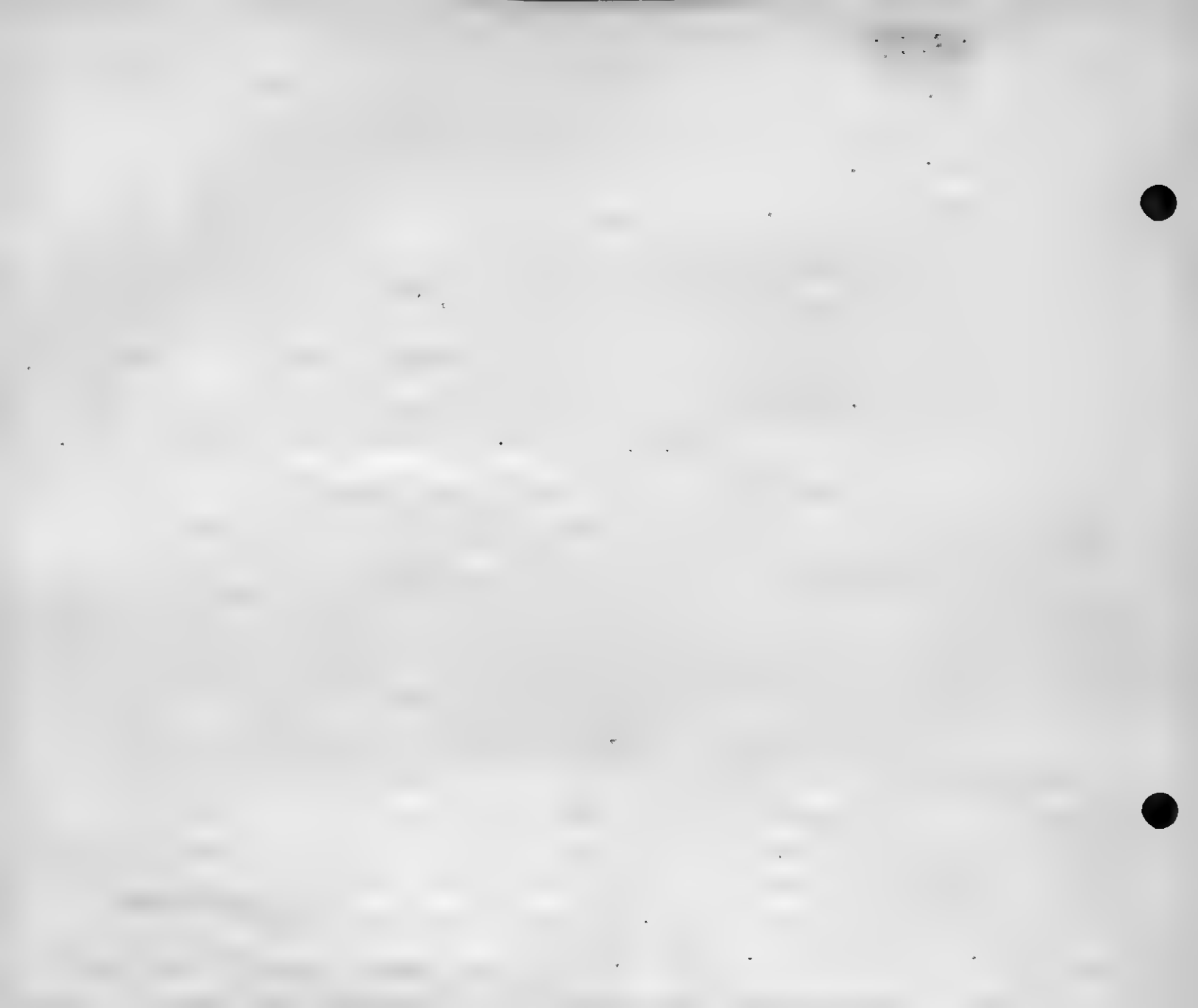
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b> c. LENGTH OF STAY IN 1b <b>4 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>College Manor, Inc.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monkton</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edith GAYNOR PARK</b>		4. DATE OF DEATH Month <b>5</b> Day <b>1</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1890 July 9, 1890*</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Brooklyn, New York.</b>
12. CITIZEN OF WHAT COUNTRY <b>U S A.</b>		13. FATHER'S NAME <b>William J. Gaynor</b>	
14. MOTHER'S MAIDEN NAME <b>Ruth Mayer</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>	
16. SOCIAL SECURITY NO. <b>220-44-4582</b>		17. INFORMANT <b>Mrs. Fairfield Coogan, Unionville, Penna.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. Cerebrovascular accident.</b> DUE TO (b) <b>2. Arteriosclerotic heart disease.</b> DUE TO (c) <b>3. arterial Hypertension.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b>3:15 PM</b> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 28</b> to <b>May 1</b> , 1966, that (I) (we) last saw the deceased alive on <b>May 1</b> , 1966, and that death occurred at <b>3:15 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>JAMES H. HAMED, M.D.</b>		22b. DATE SIGNED <b>5/1/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES H. HAMED, M.D.</b>		22d. ADDRESS <b>1227 DULANEY VALLEY RD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 4, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. James Church Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Monkton, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Brooks Towson</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

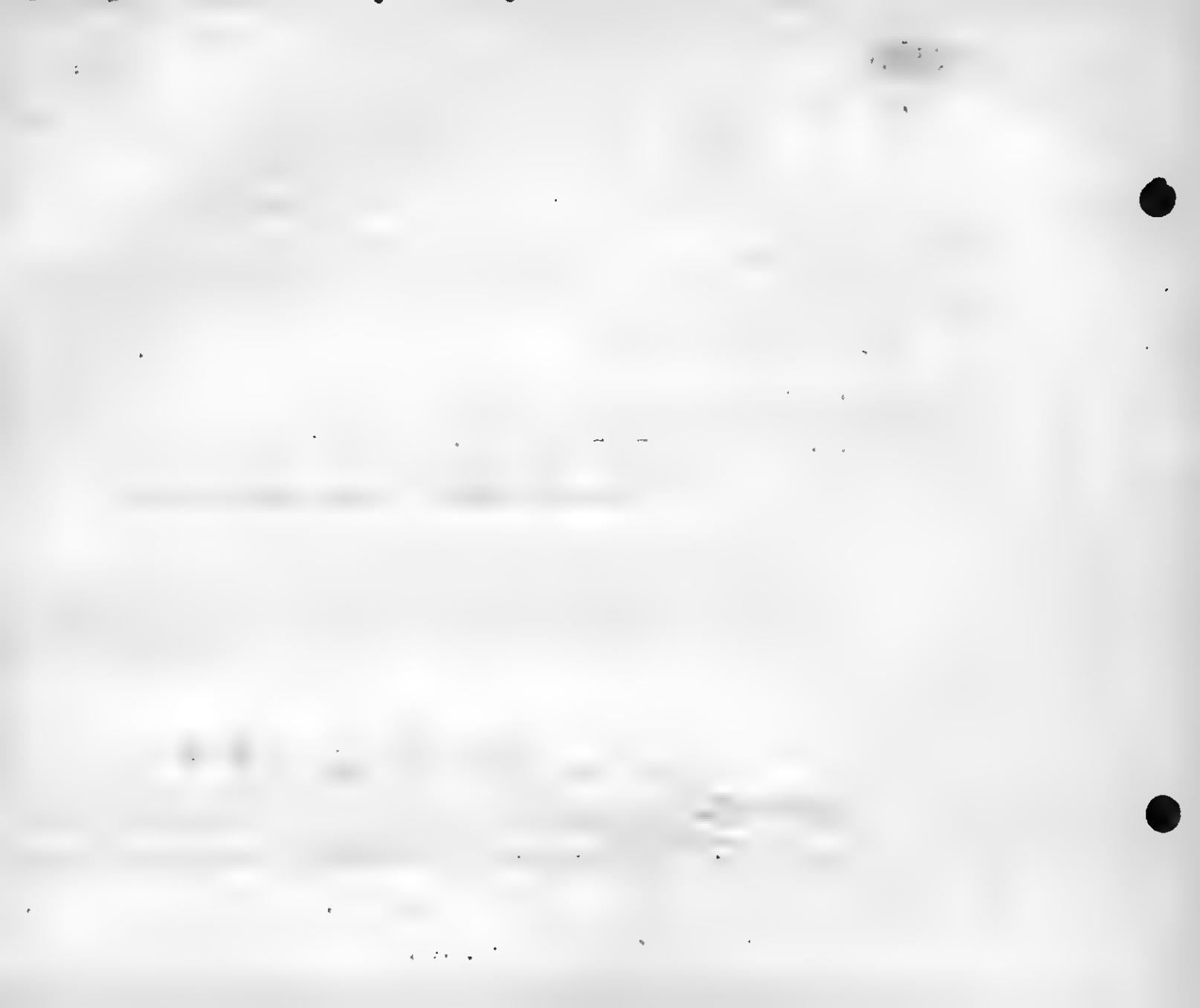
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M  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06620

## CERTIFICATE OF DEATH

06614

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN 1b <b>1/2 hour</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>5510 SOUTH BEND ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MACK</b> Middle <b>PARKER</b> Last <b>PARKER</b> 4. DATE OF DEATH Month <b>5</b> Day <b>27</b> Year <b>1966</b>		5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>12/20/04</b> 9. AGE (In years last birthday) <b>61</b> yrs. IF UNDER 1 YEAR: Months <b>6</b> Days <b>1</b> IF UNDER 24 HRS.: Hours <b>1</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Jewelry</b> 11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Eugene G. Parker</b> 14. MOTHER'S MAIDEN NAME <b>Annie Hair</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>W.W. II</b> 16. SOCIAL SECURITY NO. <b>212-03-1097</b> 17. INFORMANT <b>Mrs. Nancy Parker</b> Address <b>Same</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMATOSIS</b> <b>1621</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. <b>19</b> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>8-30 pm 5/27 1966</b> , to <b>9:00 pm 5/27 1966</b> , that (I) (we) last saw the deceased alive on <b>5/27 1966</b> , and that death occurred at <b>9:00 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>[Signature]</b> M.O. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>5/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LOIS MARY ACHIMOVICH</b> 22d. ADDRESS <b>GREATER BALTIMORE MED. CENTER</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>5-31-66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b> 23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b> ADDRESS <b>21212 4905 York Road Balto. Md.</b> 25a. REC'D BY REGISTRAR <b>MAY 31 1966</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

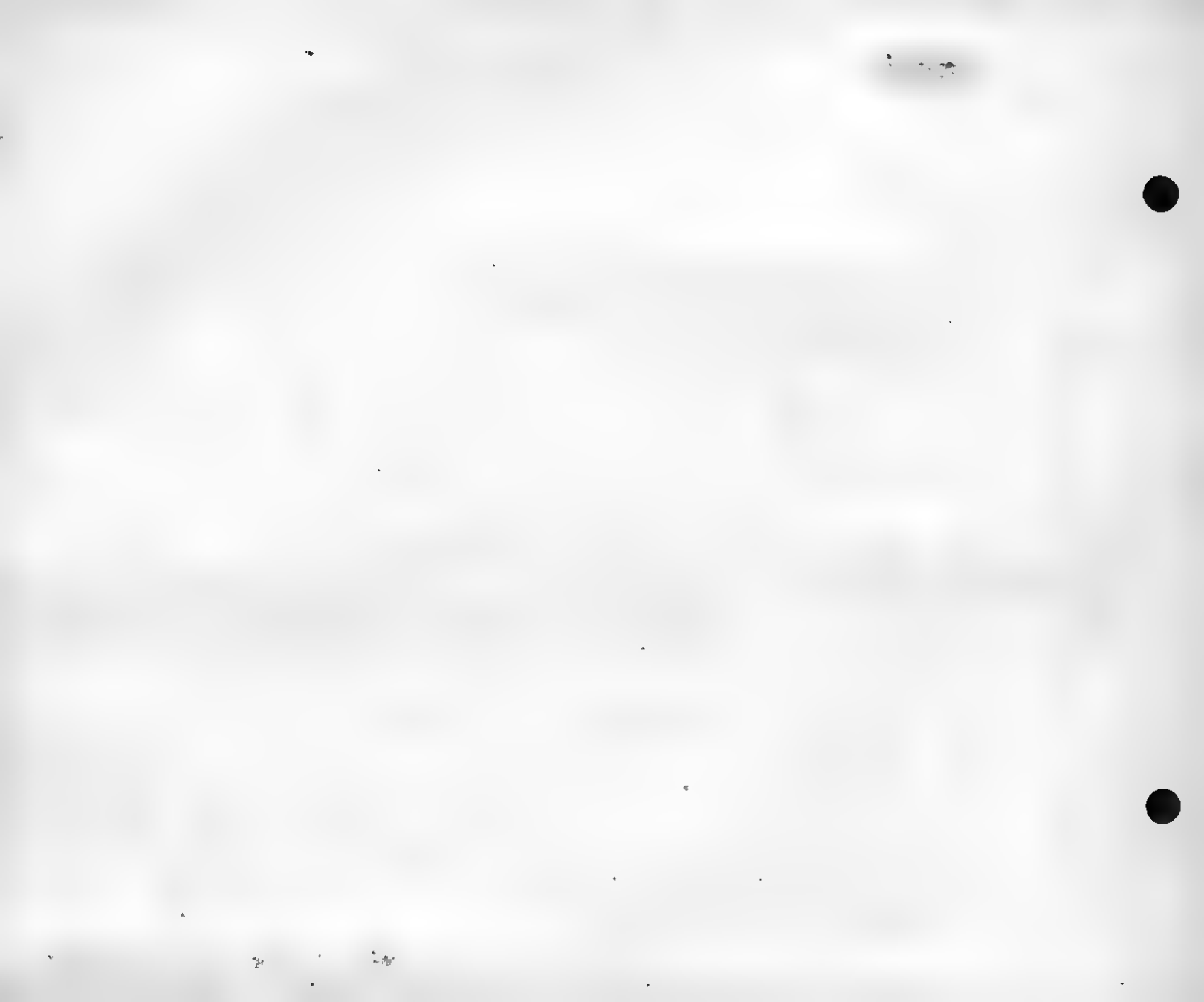
VR A15 (4)  
20 M 1/66

06621

CERTIFICATE OF DEATH

06615

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>4 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>1036 BRENTWOOD AVE.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>JAMES (NMI) PATTERSON</b>		4. DATE OF DEATH Month Day Year <b>MAY 8, 19 66</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>FEBRUARY 14, 1899</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>CONSTRUCTION</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	
11. BIRTHPLACE (County & State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>MORTON PATTERSON</b>		14 MOTHER'S MAIDEN NAME <b>Barbara E. Bigam</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16 SOCIAL SECURITY NO <b>214 18 19 89</b>	
17 INFORMANT <b>VA Hospital</b>		Address <b>Fort Howard, Maryland (Clinical Records)</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACEREBRAL HEMORRHAGE, LEFT</b> DUE TO <b>CEREBRAL ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>BRONCHOPNEUMONIA, BILATERAL</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>MAY 4</b> , 19 <b>66</b> , to <b>May 8</b> , 19 <b>66</b> , that <del>(A)</del> (we) last saw the deceased alive on <b>MAY 8</b> , 19 <b>66</b> , and that death occurred at <b>11:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>John D. Talbert</i>		22b. DATE SIGNED <b>5/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5/13/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>
24 FUNERAL DIRECTOR <b>WM. COOK BROOKS FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>DATE 5/12/66</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (2)  
6M 1/66

06622

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 2, 9 Film 3276 5/18/66 mh

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06616

1 PLACE OF DEATH a. COUNTY <b>Baltimore, Baltimore, MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Rural- Dundalk</b>		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Baltimore - rural</b>	
c. LENGTH OF STAY IN 1b <b>life</b>		d. STREET ADDRESS <b>1217 Cavendish Way</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Roadside creek near Sparrows Point Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>ALVIN L PERRY</b>		4 DATE OF DEATH Month Day Year <b>May 13 66</b>	
5. SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>II-13-1923</b>
9a. AGE (in years last birthday) yrs <b>42 43</b>		9b. F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gilbratter Ind W. Virginia</b>	
11 BIRTHPLACE (State or foreign country) <b>U S A</b>		12 CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13 FATHER'S NAME <b>Russell Perry</b>		14 MOTHER'S MAIDEN NAME <b>Conova Ash</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Virginia Perry 1217 Cavendish Way</b>	
17 INFORMANT <b>Virginia Perry 1217 Cavendish Way</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable drowning</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>113 X</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acute alcoholism - Ingestion of barbiturates</b>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Rudiger Breiteneker, M.D.</b>		22. DATE SIGNED <b>5-14-66</b>	
EXAMINER'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>	23b. DATE THEREOF <b>5-16-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md</b>
24. FUNERAL DIRECTOR <b>Walter Taborski 1005 Dundalk Ave.</b>		25a. REC'D BY REGISTRAR <b>MAY 16 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## CERTIFICATE OF DEATH

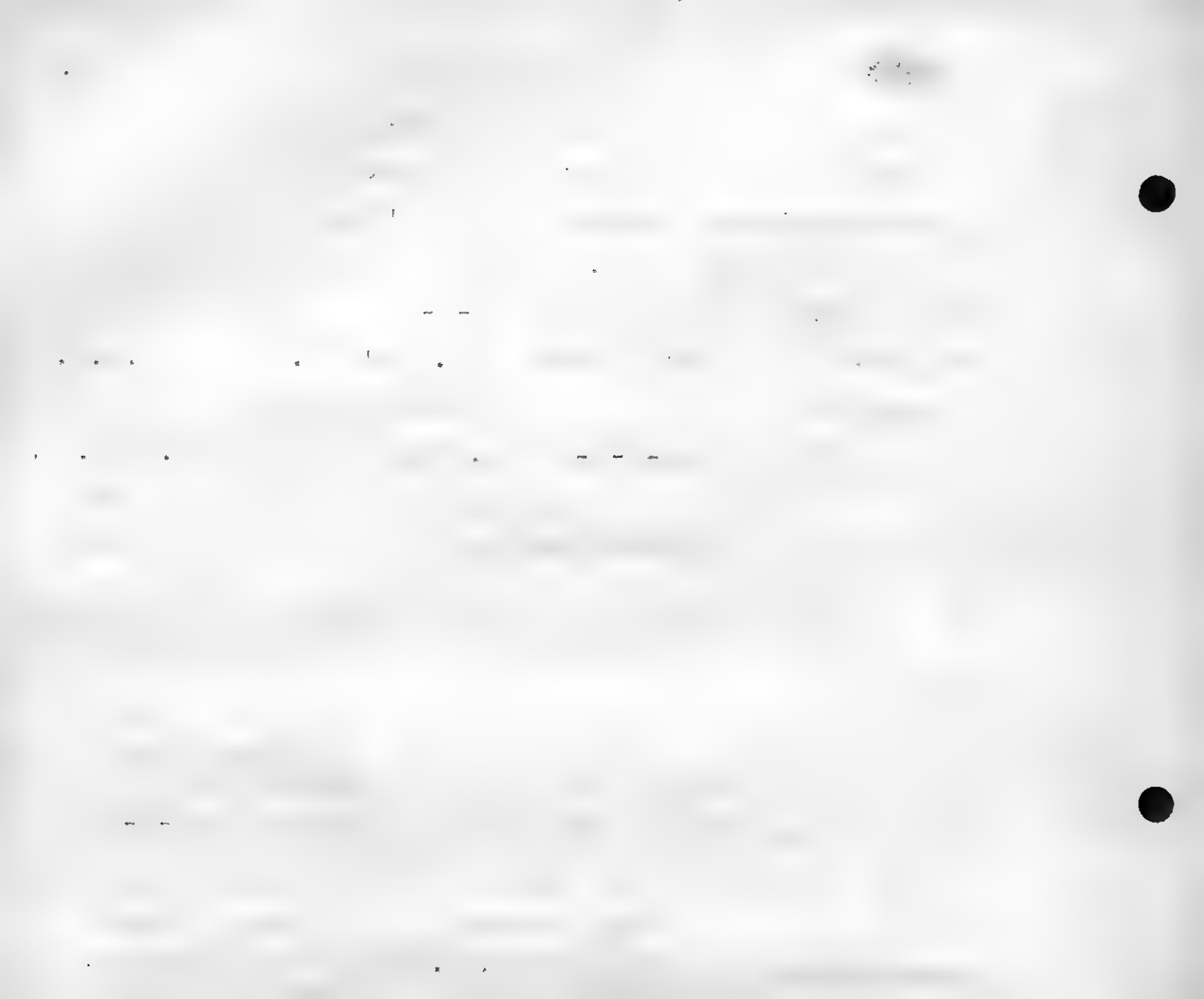
06623

06617

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>26 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>Rice's Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH E. PERRY</b>		4 DATE OF DEATH Month Day Year <b>MAY 28 19 66</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8-17-97</b>
9 AGE (In years last birthday) yrs <b>68</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>Ship Builder</b>		11 BIRTHPLACE (County & State, or foreign country) <b>St. Mary's, Mo.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13 FATHER'S NAME <b>William Perry</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Yallowee</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 1</b>	
16 SOCIAL SECURITY NO. <b>213-1-5501</b>		17 INFORMANT <b>Thelma A. Perry - Address SAME</b> <b>Clin. Records, VA Hospital, Ft. Howard, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>GASTROINTESTINAL HEMORRHAGE</b> DUE TO (b) <b>MYOCARDIAL INFRACTION</b> DUE TO (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>May 2</b> , 19 <b>66</b> , to <b>May 28</b> , 19 <b>66</b> that (1) (we) last saw the deceased alive on <b>May 28</b> , 19 <b>66</b> , and that death occurred on <b>May 28</b> , 19 <b>66</b> at <b>11:30 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Holden E. Perry</i>		22b. DATE SIGNED <b>5-28-66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6-1-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24 FUNERAL DIRECTOR <b>Ellsworth Armacost Funeral Home</b>		25a REC'D BY REGISTRAR <b>1 1966</b>	
25b REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND Items 3 & 9 Film G 376 5/20/66											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21204</b>				d. STREET ADDRESS <b>224 Linden Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>											
3. NAME OF DECEASED (Type or print) First <b>Howard Harold</b> Middle <b>Herman</b> Last <b>Phipps</b>						4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>19 66</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-23-1911</b>		9. AGE (in years last birthday) <b>54 55</b> yrs.		IF UNDER 1 YEAR: Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Automotive Technical</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dr. Meade, Md.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert M. Phipps</b>						14. MOTHER'S MAIDEN NAME <b>Lillian Stamm</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>213-01-9754</b>		17. INFORMANT <b>Family records</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage left, massive</b> DUE TO (b) <b>Pneumonia, bilateral</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 5, 19 66</b> , to <b>May 13, 19 66</b> , that (I) (we) last saw the deceased alive on <b>May 13, 19 66</b> , and that death occurred at <b>9:10 M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>D.R. Govinda Rao</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>May 13, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>D.R. Govinda Rao, M.D.</b>						22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 16, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Parkville, Maryland</b>			
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>						25a. REC'D BY REGISTRAR <b>MAY 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

MEDICAL CERTIFICATION









# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06626

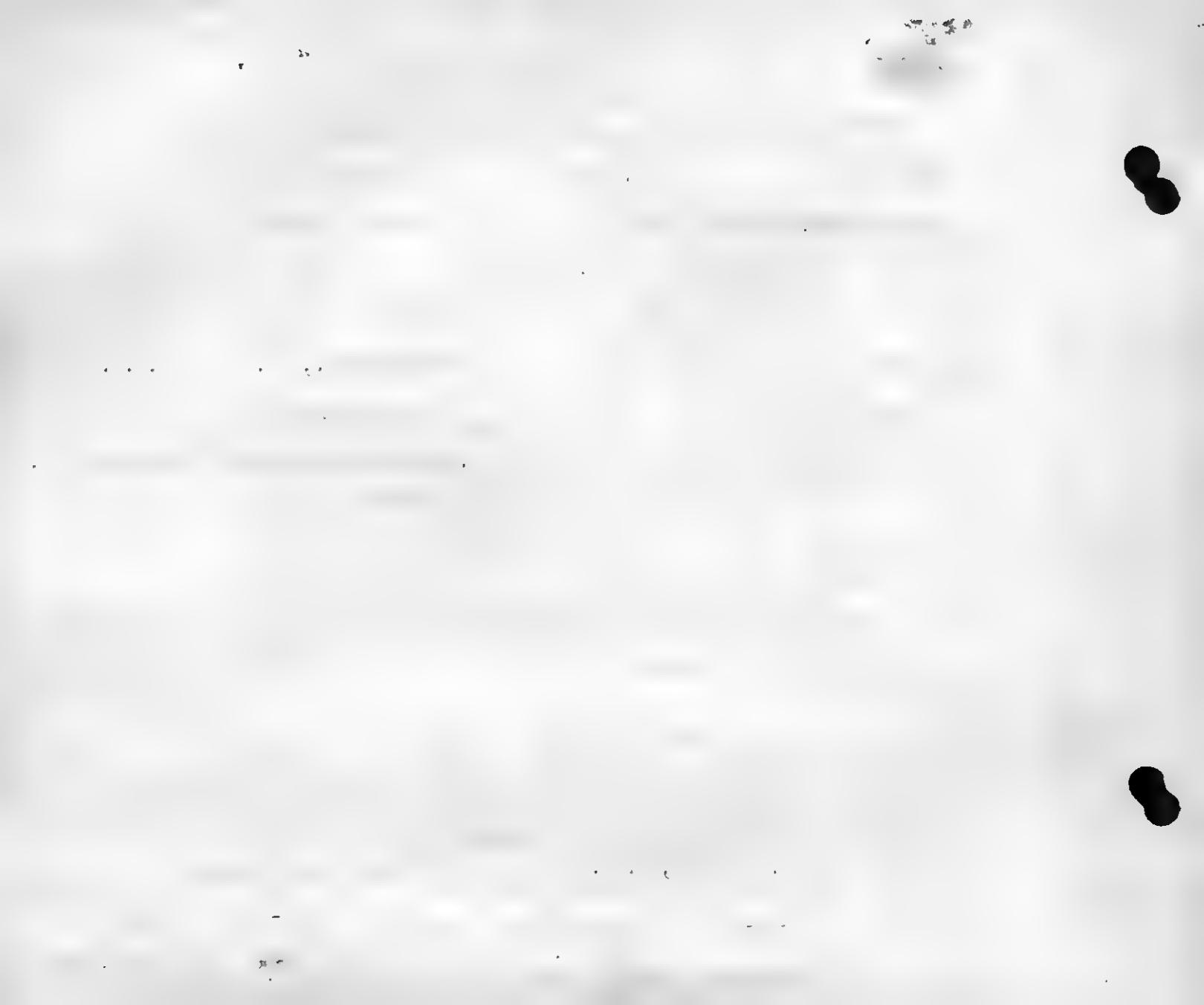
06620

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>14 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>1806 BRADDISH AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>A.</b> Last <b>POPE</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>16</b> Year <b>19 66</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3/30/90</b>
9 AGE (In years last birthday) yrs <b>76</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MONTGOMERY CO., MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOSEPH POPE</b>	
14. MOTHER'S MAIDEN NAME <b>MATILDA THOMPSON</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>	
16. SOCIAL SECURITY NO <b>219 07 21 93</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTICEMIA, DUE TO UNDETERMINED CAUSE</b> DUE TO (b) <b>0534</b> DUE TO (c) <b>0534</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5/2/66</b> , 19 to <b>5/16/66</b> , 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>5/16/66</b> , 19, and that death occurred at <b>11:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>J. D. Talbert</b>		22b. DATE SIGNED <b>5/16/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5-19-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>Robert C. Altenburg</b>		25. REGISTRAR'S SIGNATURE <b>Robert C. Altenburg</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66



CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b <u>4mons</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>(Son's Home)</u> <u>3 North Prospect Ave.</u>				d. STREET ADDRESS <u>5115 Greenwich Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Theodore F. POTTAST</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>4/29/1875</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		10. UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		11. UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>POTTAST</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>215-05-1916</u>			
17. INFORMANT <u>Berthold Pottast</u>				Address <u>3N Prospect Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Artery Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>Year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>63</u> to <u>5/27</u> 19 <u>66</u> that I last saw the deceased alive on <u>5/15</u> 19 <u>66</u> , and that death occurred at <u>7:45P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James Nolan</u>				DATE SIGNED <u>5/28/66</u>			
PHYSICIAN'S NAME (Type) <u>J. J. NOLAN</u>				ADDRESS (Street, city or town, state) <u>Baltimore MD 21229</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/30/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter F. D. 4101 Edmondson</u>				24a. REC'D BY REGISTRAR <u>MAY 31 1966</u>			
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				24c. REGISTRAR'S SIGNATURE			

BPD



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

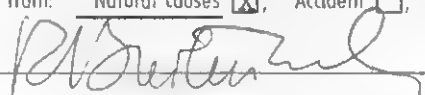
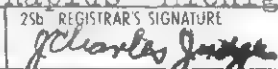
VR A15ME (5)  
6M 1/66

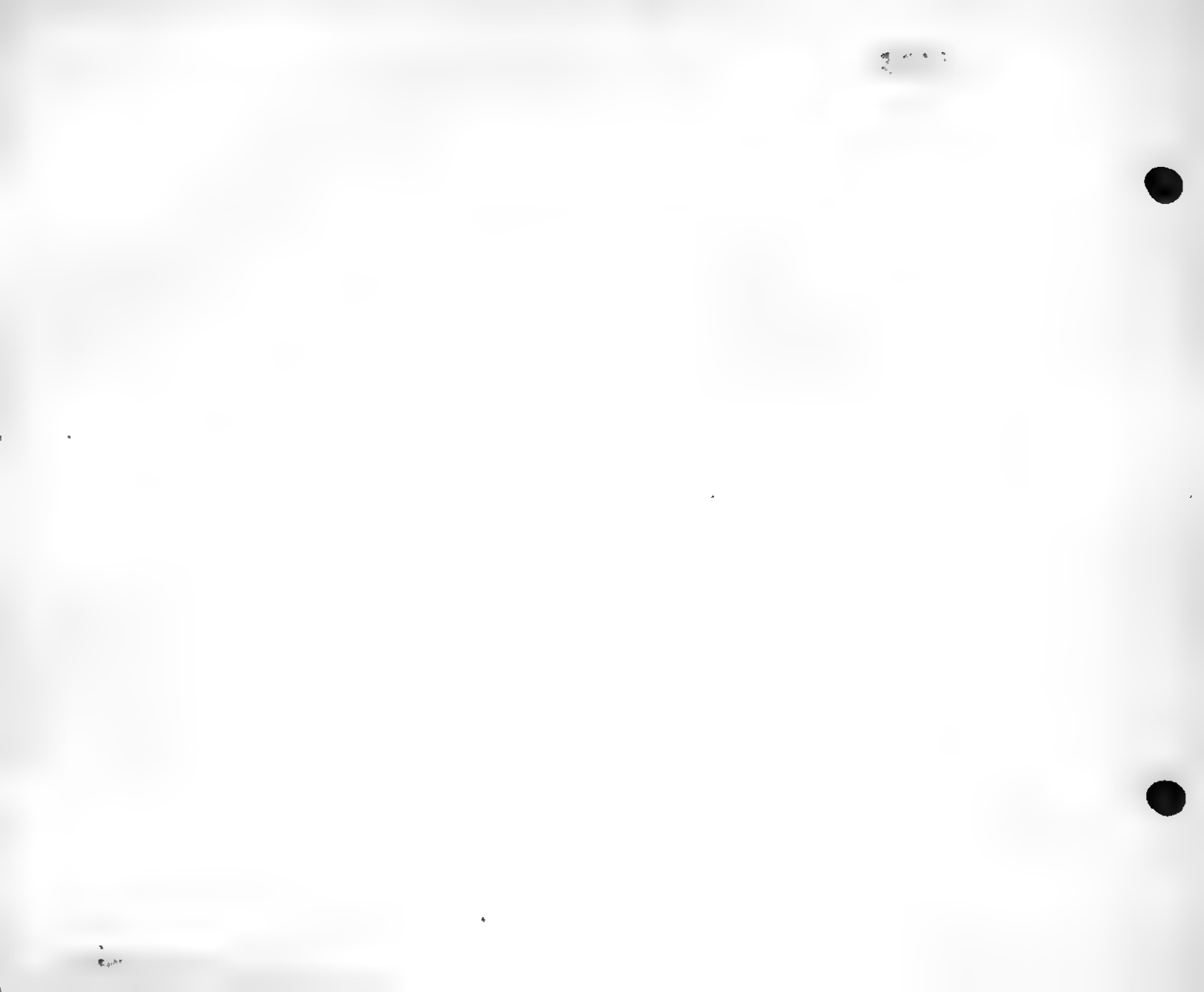
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06622

06622

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural Towson</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>505 Epson Road Towson</b>		d. STREET ADDRESS <b>505 Epson Road</b>	
3 NAME OF DECEASED (Type or print) <b>MARGARET GRAHAM PRENTICE</b>		4 DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>10/15/1914</b>
9 AGE (In years last birthday) <b>51</b> yrs		10 IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>19</b> Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11 BIRTHPLACE (State or foreign country) <b>Fort William, Ontario</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Edward R. Jones</b>		14 MOTHER'S MAIDEN NAME <b>Nellie Comer</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>---</b>	
17 INFORMANT <b>Harry H. Prentice</b>		Box <b>34A</b> Address <b>Salem Church Rd Rocks, Maryland</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatty metamorphosis of the liver</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>5-11-66</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>5/14/1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>Oak Hill</b>	23d LOCATION (City or Town) (County) (State) <b>Grand Rapids Michigan</b>
24. FUNERAL DIRECTOR <b>Charles E. Kutz</b>		25a REC'D BY REGISTRAR <b>MAY 13 1966</b>	
ADDRESS <b>Frederickville, Md.</b>		25b REGISTRAR'S SIGNATURE 	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06623

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Baltimore</b>		c. LENGTH OF STAY IN <b>17</b> years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Augsburg Lutheran Home 6811 Campfield</b>		d. STREET ADDRESS <b>202 N. Chapel Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Theresa</b> Last <b>Prieber</b>		4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/14/76</b>
9. AGE (In years last birthday) <b>89</b> yrs		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing Mfg.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZENSHIP OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry A. Steinkraus</b>		14. MOTHER'S MAIDEN NAME <b>Louise (unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-01-5654</b>	
17. INFORMANT <b>Paul A. Hauer, 6811 Campfield Road 21207</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Primary carcinoma of Cx</b> DUE TO <b>Breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Generalized carcinoma</b> (b) <b>Generalized carcinoma</b> DUE TO <b>Generalized carcinoma</b> (c) <b>Arterio Sclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b> <b>1 yr.</b> <b>5 yrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Sclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 4, 1966</b> to <b>May 4, 1966</b> that (I) (we) last saw the deceased alive on <b>April 24, 1966</b> , and that death occurred at <b>10:45 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Earl L. Chambers</b>		22b. DATE SIGNED <b>5/5/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>		22d. ADDRESS <b>4168 Liberty St. Balto. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>5/7/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Cem</b>	23d. LOCATION (City or town) (County) (State) <b>Balto Co</b>
24. FUNERAL DIRECTOR <b>P. A. Deemman 6667 Harford</b>		25a. RECD BY REGISTRAR <b>RE MAY 11 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

1/11

1/11



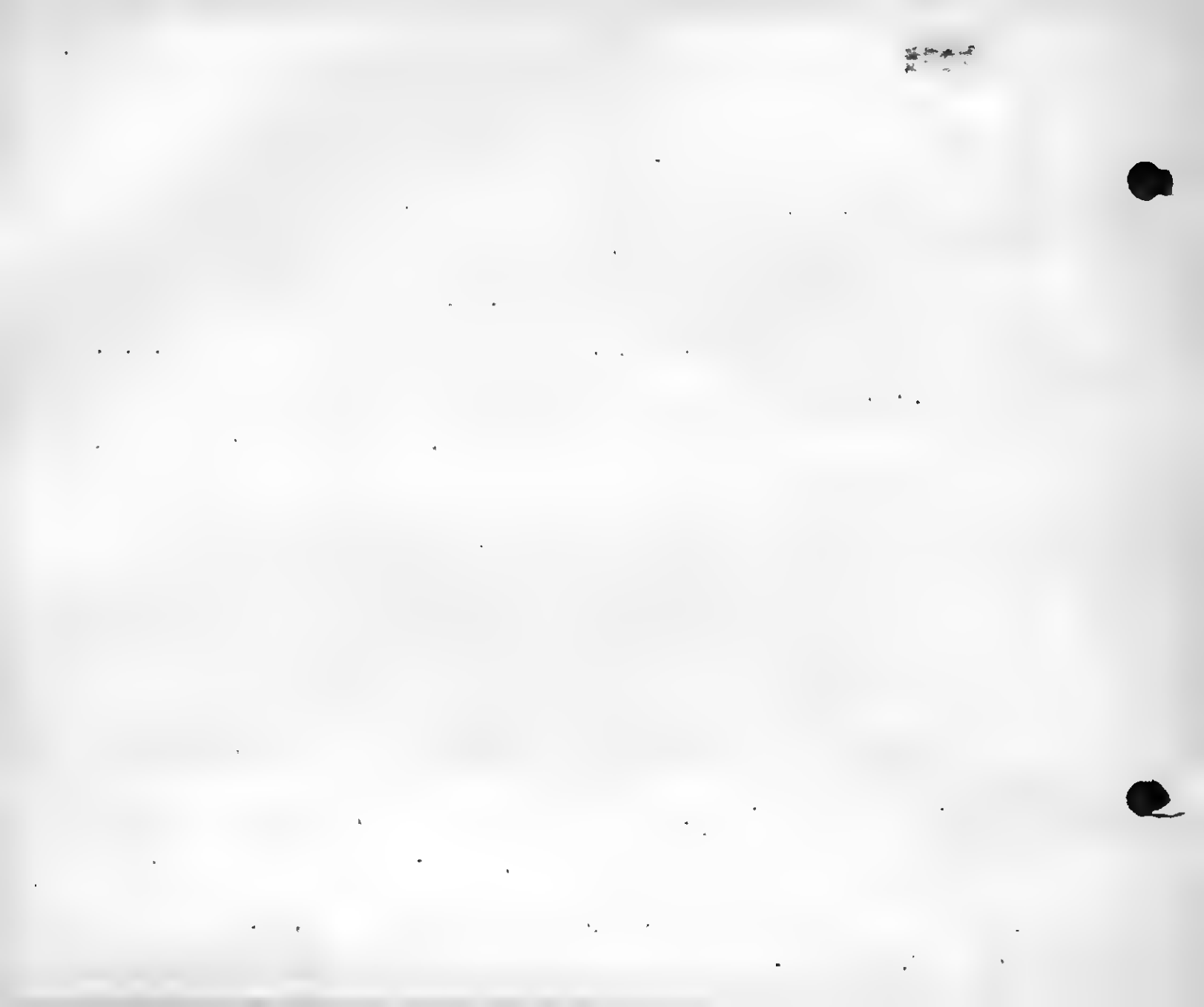
CERTIFICATE OF DEATH

Reg. Dist. No.

06624

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>			
c. LENGTH OF STAY IN 1b <b>35 years</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3312 Offutt Road</b>				d. STREET ADDRESS <b>3312 Offutt Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Walter Alexander Proctor</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 7, 1899</b>	
9. AGE (In years lost birthday) <b>67 yrs</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Western Md. Dairy</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John C. Proctor</b>		14. MOTHER'S MAIDEN NAME <b>Able</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>216-10-8461</b>		INFORMANT Address <b>Helena B. Proctor 3312 Offutt Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4301</b> DUE TO <b>Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>7</b>
20a. ACC. DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>[Signature]</b>				PHYSICIAN'S NAME (Type) <b>[Signature]</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-24-66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Balto, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>				ADDRESS <b>4600 Liberty Heights</b>		24. REC'D BY REGISTRAR <b>MAY 24 1966</b>	
				24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 06625

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise N.H.</u>		d. STREET ADDRESS <u>503 Collins Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>K.</u> Last <u>QUINN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/10/1876</u>
9. AGE (In years, last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>10</u> Hours <u>45</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Pfaff</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Brain Syndrome</u> DUE TO (c) <u>Associated with Cerebral Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>70 yrs. 10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Associated with Cerebral Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>5</u> Day <u>27</u> Year <u>1966</u> Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>503 Collins Ave</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/26/66</u> 19 <u>66</u> to <u>5/27/66</u> 19 <u>66</u> , that I last saw the deceased alive on <u>5/26/66</u> and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W E Mc Graw MD</u>		DATE SIGNED <u>5/28/66</u>	
PHYSICIAN'S NAME (Type) <u>W E Mc Graw MD</u>		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 30, 1966</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nitche F.P.</u>		ADDRESS <u>4101 Edmondson Ave</u>	
24a. REC'D BY REGISTRAR <u>Charles Judge</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 31 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

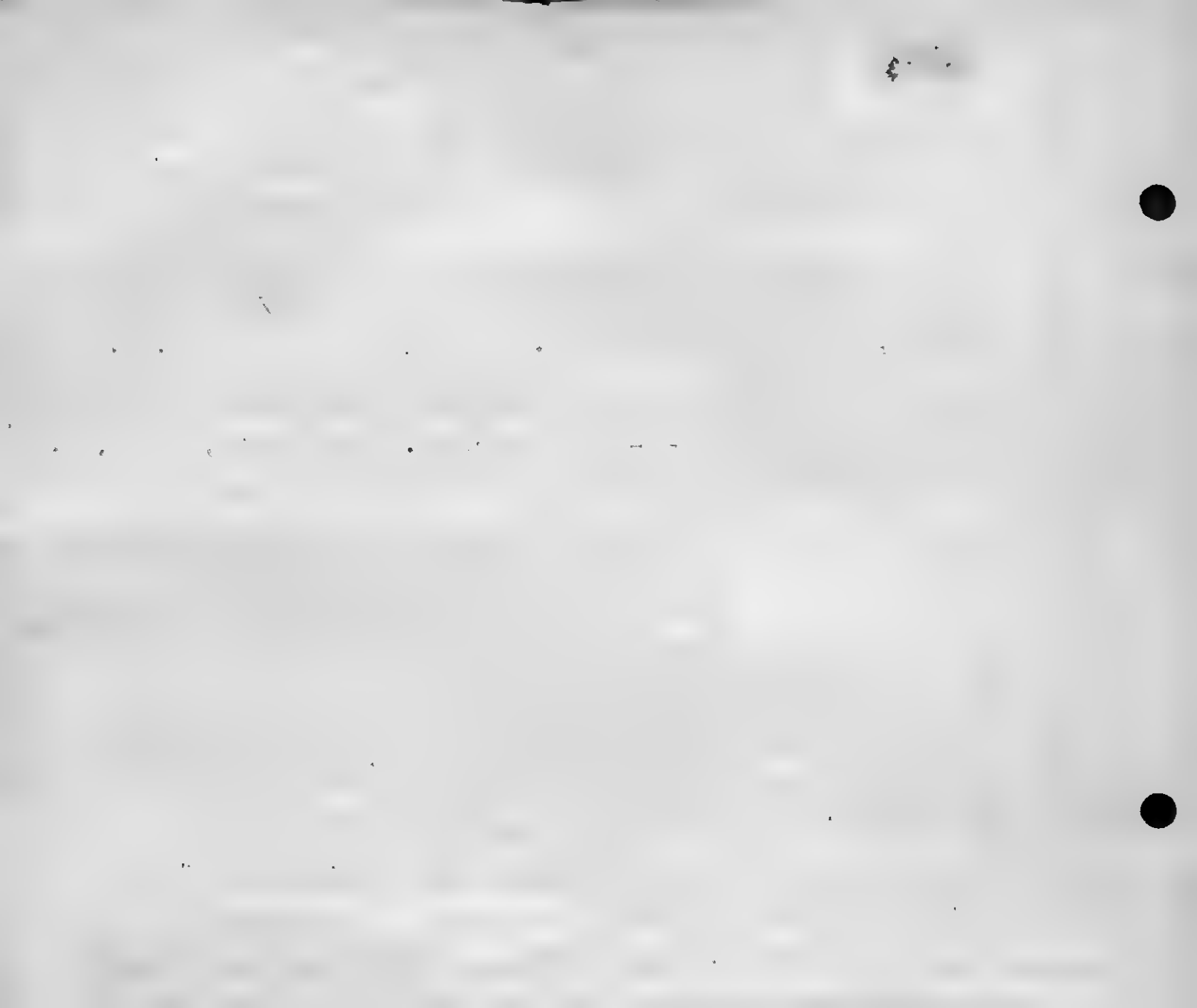
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05632

06626

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> c. LENGTH OF STAY IN 1b <u>11 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ivy Hall Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROSEDALE</u> d. STREET ADDRESS <u>1209 Krueger Avenue 21206</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>George W. Raftery</u>		<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>15</u> Year <u>1966</u>		<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Aug 31 1898</u> <b>9. AGE</b> (In years last birthday) <u>67</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired,</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Continental Can Co.</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Thomas Raftery</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Bauerschmidt</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>216-05-7706</u> <b>17. INFORMANT</b> <u>Sister, Mrs. Barbara Brazier, Rosedale, Md. 6</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crownary occlusion</u> <u>4801</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease 5 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>		<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> (County) (State) <u>  </u>					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan 1 1964</u> <b>to</b> <u>5/15 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>5/14 1966</u> <b>and that death occurred at</b> <u>12 M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>G. M. Baumgardner</u> <b>M.D.</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>G. M. Baumgardner</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>Balto 6 Md</u>		<b>22b. DATE SIGNED</b> <u>5/15/66</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>May 18-1966</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Sacred Heart of Jesus</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Dundalk, Maryland 21222</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>JOHN J. DUDA, Baltimore, Maryland 21224</u> <b>25a. REC'D BY REGISTRAR</b> <u>MAY 18 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Charles Judge</u>					





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05638

06627

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN ARM</u> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DULANEY VALLEY RD S. OF MAJOR RD.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN ARM</u> d. STREET ADDRESS <u>DULANEY VALLEY RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MICHELLE LYNN REATHER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 11, 1956</u>
9. AGE (In years last birthday) <u>10 yrs.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Roland Park Country</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>C. William Reather</u>		14. MOTHER'S MAIDEN NAME <u>Beverly G. George</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FAMILY RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE AND EDEMA</u> <u>8184</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>DEPRESSED COMPOUND SKULL FRACTURE</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>THROWN BY HORSE WHICH WAS STRUCK BY AUTOMOBILE</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4</u> <u>p.m.</u> <u>MAY 13, 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>ROAD</u>		20f. (City or town) (County) (State) <u>GLEN ARM BALTO. MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William A. Pillsbury</u>		22. DATE SIGNED <u>5/15/66</u>	
EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>		M.D. <u>TIMOTHY M. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-17-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Cockeysville, Md.</u>	
24. FUNERAL DIRECTOR <u>John Banno Sons</u>		25a. REC'D BY REGISTRAR <u>MAY 23 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06634

06628

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>83 Kinship Road</b>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>NMI</b> Last <b>REINERT</b>		4. DATE OF DEATH Month <b>5</b> Day <b>11</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/9/03</b>
9. AGE (In years lost birthday) <b>63 yrs</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Argcuture</b>	11. BIRTHPLACE (County & State, or foreign country) <b>McKeesport, Penn.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>MATTHEW REINERT</b>	
14. MOTHER'S MAIDEN NAME <b>ANNA ADLER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>	
16. SOCIAL SECURITY NO <b>225 52 54 48</b>		17. INFORMANT <b>CLINICAL RECORDS</b> Address <b>V.A. HOSPITAL, FORT HOWARD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>THROMBOSIS OF RIGHT MIDDLE CEREBRAL ARTERY</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/11</b> , 19 <b>66</b> on <b>5/11</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>5/11</b> , 19 <b>66</b> , and that death occurred at <b>4:00 A.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <i>Peter Juvan</i>		22b. DATE SIGNED <b>5/11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>PETER JUWAN, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>May 13/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>ULLRICH FUNERAL HOME</b>		25a. DATE BY REGISTRAR <b>MAY 18 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S NAME <b>DUNDALK AVENUE, BALTIMORE, MD.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>BALTIMORE</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>		c LENGTH OF STAY IN 1b <b>6 YEARS.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1005 W. SEMINARY AVE</b>		d STREET ADDRESS <b>1005 W. SEMINARY</b>	
3 NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>M.</b> Last <b>REINOLDI</b>		4 DATE OF DEATH Month <b>MAY</b> Day <b>17</b> Year <b>1966</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>AUG 19, 1915</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>	9 AGE (In years last birthday) <b>50</b>
11 BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>SAMUEL REINOLDI</b>		14 MOTHER'S M A DEN NAME <b>MARY MANELLA</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b> <b>WHITE</b>		16 SOCIAL SECURITY NO <b>218-09-8443</b>	17 INFORMANT Address <b>MRS ANNA REINOLDI</b> <b>SAME</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles E. Howell</b> (M.D.)		22. DATE SIGNED <b>5/17/66</b>	
EXAMINER'S NAME (Type) <b>CHARLES E. HOWELL</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>MAY 20, 1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d LOCATION (City or town) (County) (State) <b>BALTIMORE</b> <b>MARYLAND</b>
24 FUNERAL DIRECTOR <b>Wm Cook</b> <b>BROOKS TOWSON</b>		25a REC'D BY REGISTRAR <b>MAY 23 1966</b>	
ADDRESS <b>1050 YORK RD TOWSON, MD 21204</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

**06636**

**06630**

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> c. LENGTH OF STAY IN 1b <u>3yrs. 8mos</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Masonic Home of Md.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived if institut an; Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>—</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>705 Chapelgate Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3 NAME OF DECEASED</b> (Type or print) <u>Louis Frederick Reppert</u> First Middle Last <b>4 DATE OF DEATH</b> Month <u>5</u> Day <u>14</u> Year <u>1966</u>				<b>5 SEX</b> <u>M</u> <b>6 COLOR OR RACE</b> <u>W</u> <b>7 MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8 DATE OF BIRTH</b> <u>11-15-88</u> <b>9 AGE</b> (In years last birthday) <u>77</u> yrs <b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Craftsman</u> <b>10b KIND OF BUSINESS OR INDUSTRY</b> <u>—</u> <b>11 BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Md.</u> <b>12 CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>					
<b>13 FATHER'S NAME</b> <u>George W. Reppert</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Sophia Medinger</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO</b> <u>216-05-2355A</u> <b>17 INFORMANT</b> <u>Masonic Home of Md.</u> Address <u>—</u>					
<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1, Arteriosclerotic heart disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>2, Chronic lung disease</u> DUE TO (c) <u>3, Carcinoma of prostate</u> <u>4, uremia</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>August 15 1965 - May 14 1966.</u>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21 I certify that (I) (this hospital) attended the deceased from August 15, 1965, to May 13, 1966, that (I) (we) last saw the deceased alive on May 14, 1966, and that death occurred at 12:00 P.M. from causes and on the date stated above.</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>22a. SIGNATURE</b> <u>Jamshid Hamed MD</u>				<b>22b. DATE SIGNED</b> <u>5/14/66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>JAMSHID HAMED MD</u>		<b>22d. ADDRESS</b> <u>1227 Dulaney Valley</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>5-16-1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Grand Ridge</u>		<b>23d. LOCATION (City or town) (County) (State)</b> <u>Beltsville Balto. Md</u>	
<b>24. FUNERAL DIRECTOR</b> <u>211 Park Brooks Trueman</u> ADDRESS <u>1030 York Rd. Towson, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		<b>DATE</b> <u>MAY 23 1966</u>	

VR A15 (4)  
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

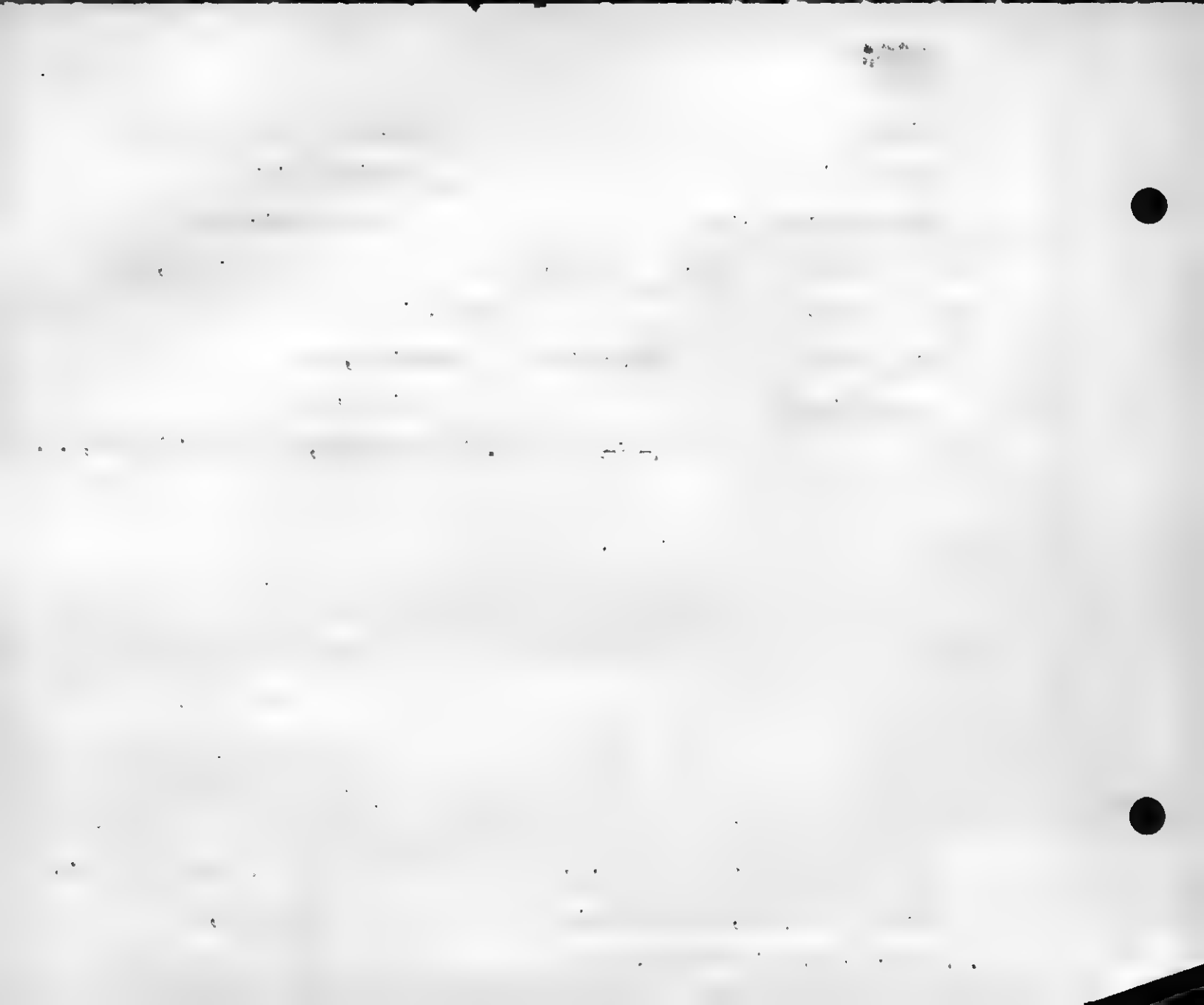




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN 15 <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>100 Frederick Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>100 Frederick Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>RAY GEORGE RINGLEY</b>					4. DATE OF DEATH <b>May 18, 1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 9, 1912</b>		9. AGE (in years last birthday) <b>53</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Borgis Brothers</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Paper Mill</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Sneedville, Tenn.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James Ringley</b>					14. MOTHER'S MAIDEN NAME <b>Alice Lawson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>227-18-3539</b>		17. INFORMANT <b>Mrs. Violet Ringley, 100 Frederick Road, E.C. Md</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> 11.21 DUE TO (b) <b>METASTATIC ADENOCARCINOMA</b> DUE TO (c) <b>BRONCHOGENIC CARCINOMA</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>3 M</b> <b>6 M</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>5-18, 1966</b> to <b>5-18, 1966</b> ; that (I) (we) last saw the deceased alive on <b>5-18, 1966</b> , and that death occurred at <b>5:45</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Peter V. Thorpe, I.D.</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5-18-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Peter V. Thorpe, I.D.</b>				22d. ADDRESS <b>409 Columbia Rd. - Howard - Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 21, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md</b>			
24. FUNERAL DIRECTOR <b>F.C. Higginbotham, Ellicott City, Md</b>				25a. REC'D BY REGISTRAR <b>MAY 20 1966</b> DATE		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



## CERTIFICATE OF DEATH

06632

06638

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c LENGTH OF STAY IN lb <b>41 DAYS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>526 N. STREEPER STREET</b>	
3 NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>ROBERT</b> Last <b>BITTER</b>		4 DATE OF DEATH Month <b>MAY</b> Day <b>15</b> Year <b>19 66</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>DECEMBER 8, 1911</b>
9 AGE (In years last birthday) yrs. <b>54</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>GAS &amp; ELECTRIC CO</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13 FATHER'S NAME <b>ANDREW BITTER --DECEASED</b>	
14 MOTHER'S MAIDEN NAME <b>MARGARET M. RAUH -- DECEASED</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>	
16 SOCIAL SECURITY NO <b>216 09 19 56</b>		17 INFORMANT <b>VA HOSPITAL</b> Address <b>(CLINICAL FOLDER) FORT HOWARD, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO (b) <b>PULMONARY EDEMA</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>Recent</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (A) (this hospital) attended the deceased from <b>APRIL 4,</b> 19 <b>66</b> , to <b>MAY 15</b> , 19 <b>66</b> , that (A) (we) last saw the deceased alive on <b>MAY 15,</b> 19 <b>66</b> , and that death occurred at <b>9:03am</b> , from causes on and on the date stated above.	
22a. SIGNATURE <b>ABDUL S. QURESHI, M.D.</b>		22b. DATE SIGNED <b>5/15/66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>VA Hospital, Fort Howard, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>5/18/66</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>2601 E. Madison St.</b>		25a. REC'D BY REGISTRAR <b>MAY 17 1966</b>	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06639

06633

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN ID <b>22 MINUTES</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>8430 Greenway Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cedric</b> Middle <b>ROBERTSON</b> Last <b>ROBERTSON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1966</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEVER EMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John A. Robertson</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Long</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No.</b>	
17. INFORMANT <b>JOHN A ROBERTSON</b>		Address <b>SAME AS 2D.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature - Twin 1st</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 29, 1966</b> to <b>May 29, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 29, 1966</b> , and that death occurred at <b>1:50 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Glocrito G. Sagisi</b>		22b. DATE SIGNED <b>May 29, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Glocrito G. Sagisi</b>		22d. ADDRESS <b>7620 York Road, 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-31-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT HILL CEMETERY</b>		23d. LOCATION (city, town or county) (State) <b>TOWSON MARYLAND</b>	
24. FUNERAL DIRECTOR <b>WM. COOK-BROOKS TOWSON</b>		25a. REC'D BY REGISTRAR <b>JUN 7 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

6-215864



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06634									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			c. LENGTH OF STAY IN ID <b>21 MINUTES</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>					d. STREET ADDRESS <b>8430 Greenway Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Xavier</b> Middle <b>ROBERTSON</b> Last <b>ROBERTSON</b>					4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 66</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 29 1966</b>		9. AGE (in years last birthday) yrs. <b>2</b> Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEVER EMPLOYED</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John A. Robertson</b>					14. MOTHER'S MAIDEN NAME <b>Barbara Long</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>John A. Robertson</b>		Address <b>SAME AS 2D</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature - Twin 2nd</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 29</b> , 19 <b>66</b> , to <b>May 29</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 29</b> , 19 <b>66</b> , and that death occurred at <b>1:50 am</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Glocrito G. Sagisi</b>					22b. DATE SIGNED <b>May 29, 1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>Glocrito G. Sagisi</b>					22d. ADDRESS <b>7620 York Road, 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-31-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>TOWSON, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks TOWSON</b>					25a. REC'D BY REGISTRAR <b>JUN 7 1966</b>				
					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
05641					06635					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)					
a. COUNTY <u>Balto.</u> MARYLAND					a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>					
c. LENGTH OF STAY IN 1b <u>35 yrs</u>					d. STREET ADDRESS <u>Old York Rd.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Clarence</u> First <u>Rosier</u> Middle <u>Rosier</u> Last					4. DATE OF DEATH <u>May 23</u> 19 <u>66</u> Month <u>May</u> Day <u>23</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 29, 1896</u>		9. AGE (In years last birthday) <u>69</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Section Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Parkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>James Rosier</u>					14. MOTHER'S MAIDEN NAME <u>Laura Jones</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.I</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>716-12-3353</u>					
17. INFORMANT <u>Mrs. Almeta Rosier</u> Address <u>Parkton, Md.</u>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema, Bronchitis</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>—</u> p.m. <u>—</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>1966</u> , that (I) (we) last saw the deceased alive on <u>5/22</u> 19 <u>66</u> , and that death occurred at <u>4:25</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>A. M. France</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>					22d. ADDRESS <u>PARKTON, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>5/26/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Freedom Cem.</u>		23d. LOCATION (City, town or county) (State) <u>New Freedom, Penna.</u>			
24. FUNERAL DIRECTOR <u>J. Jacob Hartensen</u> ADDRESS <u>New Freedom, Pa.</u>					25a. REC'D BY REGISTRAR <u>May 26 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

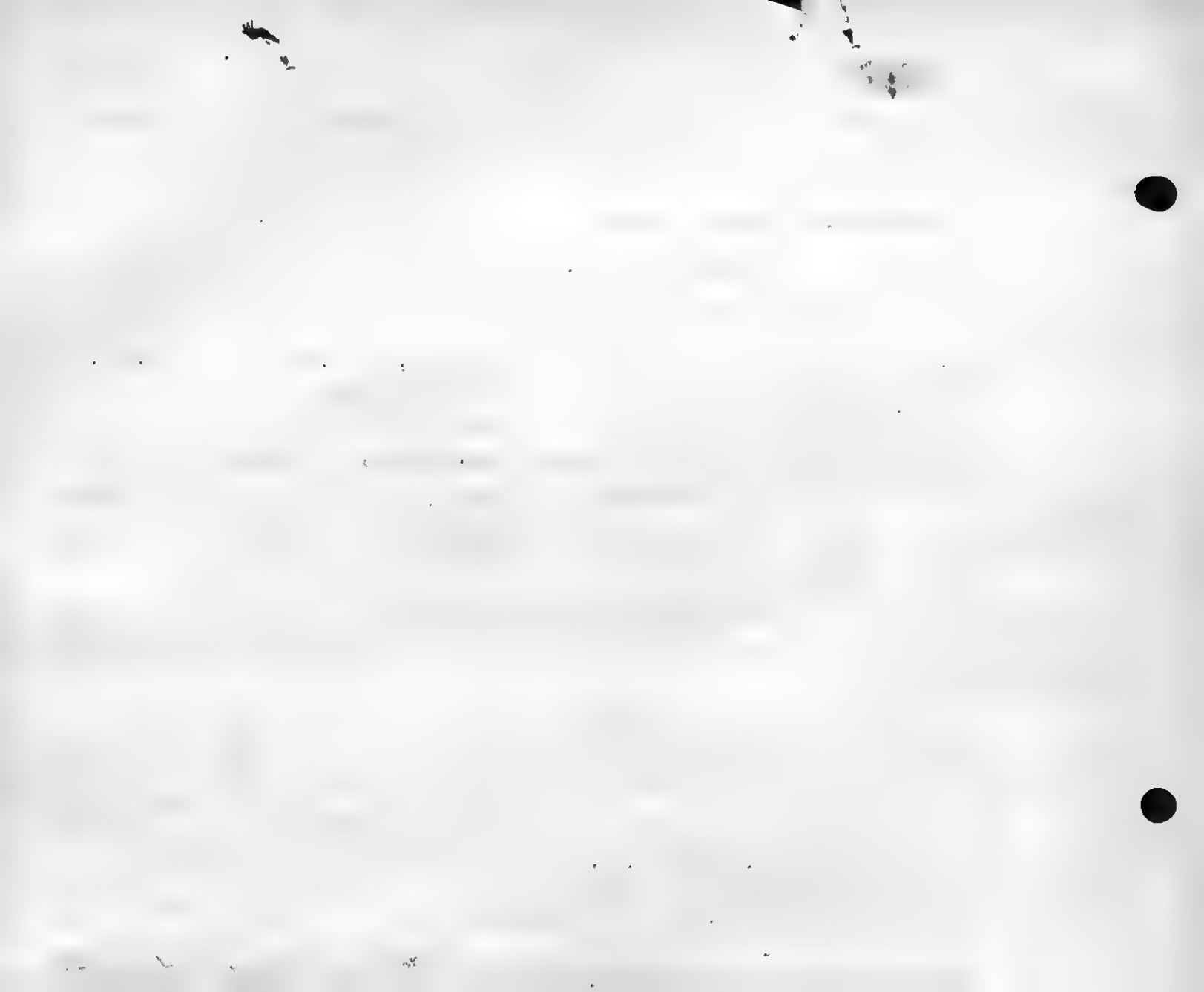
06642

06636

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>81 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>					d. STREET ADDRESS <b>125 HIGGINS STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>E.</b> Last <b>RUSSELL</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>10</b> Year <b>1966</b>			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>DECEMBER 24, 1920</b>		9. AGE (In years last birthday) <b>45</b> yrs	10. UNDECEASED 1 YEAR Months Days	11. UNDECEASED 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (County & State, or foreign country) <b>EASTON, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE RUSSELL</b>				14. MOTHER'S MAIDEN NAME <b>LAURA COPPER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO <b>213 12 53 70</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PERITONITIS, FIBRINOPURULENT ACUTE</b> DUE TO <b>PANCREATITIS, SUPPURATIVE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>6 MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>2/18/66</b> , 19__, to <b>5/10/66</b> , 19__, that <del>he</del> (we) last saw the deceased alive on <b>5/10/66</b> , 19__, and that death occurred at <b>4:55AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Peter V. Juvan</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-14-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EASTON CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>EASTON, MARYLAND</b>	
24. FUNERAL DIRECTOR <i>Jasmond Dashiell</i>				25a. REC'D BY REGISTRAR <b>MAY 16 1966</b>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

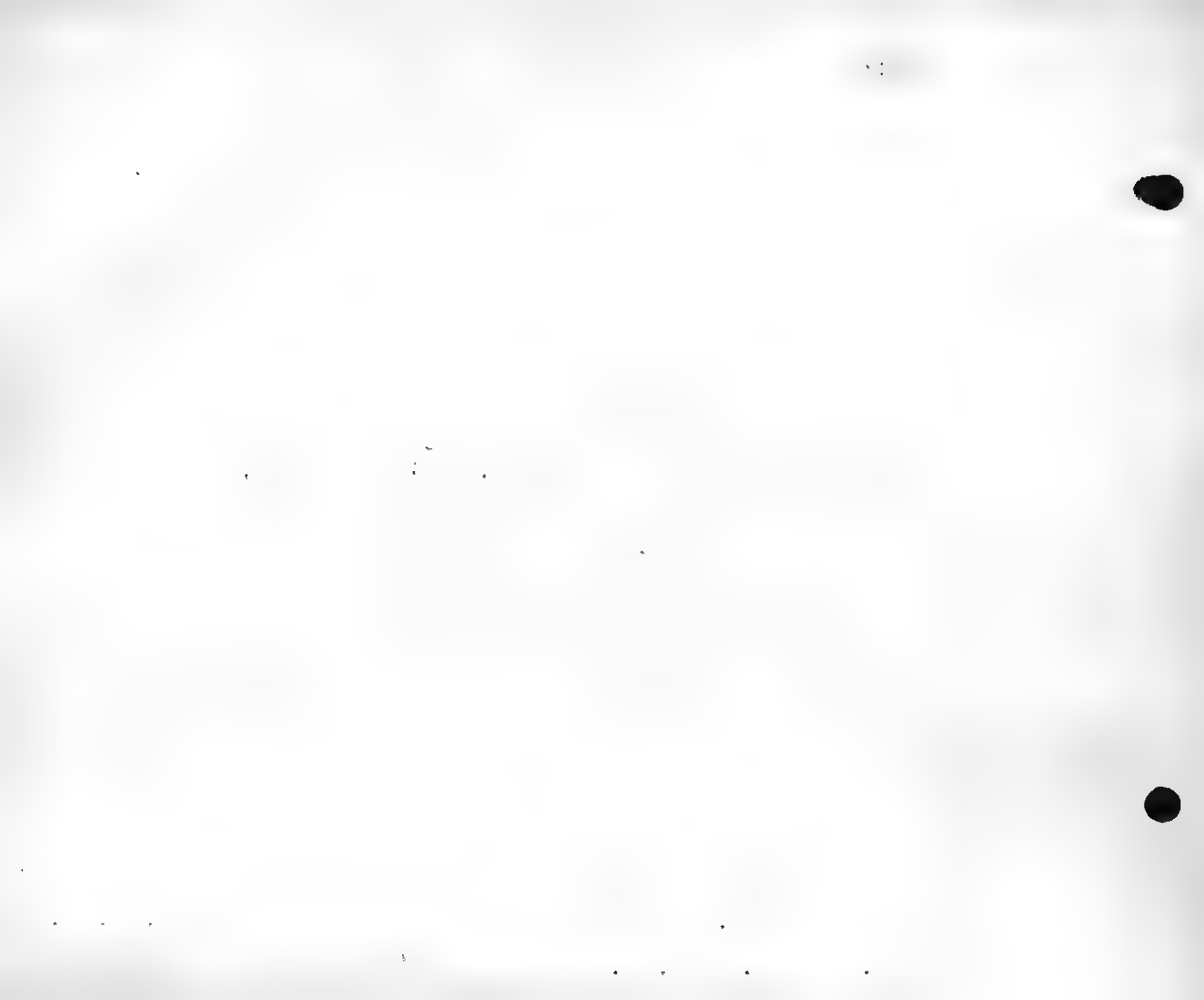
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9)  
6M 1/66

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 16 Film 3376 5/18/66 mh MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Balto.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c LENGTH OF STAY IN lb <u>4 yrs</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown, Md.</u>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3717 Collier Rd.</u>		d STREET ADDRESS <u>3717 Collier Rd.</u>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM GILBERT SCARBROUGH</u>		4 DATE OF DEATH Month <u>MAY</u> Day <u>11</u> Year <u>1966</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-23-97</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dispatcher</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Balto. Transit</u>	9 AGE (In years last birthday) <u>69</u> yrs
11 BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>Wm Thos. Scarbrough</u>		14 MOTHER'S MAIDEN NAME <u>Isabelle Mc Cleary</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No SS 213-05-9086</u>		17 INFORMANT <u>Mrs. Juanita Scarbrough</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>260X</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>arteriosclerotic C-V. Disease</u> DUE TO (c) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>5 yrs</u> <u>20 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>none</u>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 1B) <u>none</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>none</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work <u>none</u>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f (City or town) (County) (State) <u>none</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>5/14/66.</u>	23c NAME OF CEMETERY OR CREMATORY <u>Lake View Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Carroll, Co. Md.</u>
24 FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>		25a REC'D BY REGISTRAR DATE <u>MAY 13 1966</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

22 DATE SIGNED  
5-11-66



CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Handisboro</u>		c LENGTH OF STAY IN 1b <u>English Council</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. Co. Gen. Hosp</u>		d STREET ADDRESS <u>3613 ANNAPOLIS RD</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>CORA E. Schaefer</u>		4 DATE OF DEATH Month Day Year <u>5-13-1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-06</u>
9a AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>Walter G. Molesworth</u>		14 MOTHER'S MAIDEN NAME <u>ELMA Ellis</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17. INFORMANT <u>Hosp. Record</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized CARCINOMATOSIS</u> DUE TO <u>CA OF RECTUM, STOMACH</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-11-1966</u> , to <u>5-13-1966</u> , that (I) (we) last saw the deceased alive on <u>5-13-1966</u> , and that death occurred at <u>1:25 P.M.</u> , from causes and on the date stated above			
22a SIGNATURE <u>Balbino Z. Payag, Jr.</u>		22b. DATE SIGNED <u>5-13-66</u>	
22c PHYSICIAN'S NAME (Type) <u>BALBINO Z. PAYAG, JR.</u>		22d. ADDRESS <u>BALTIMORE COUNTY GEN. HOSP.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 16, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto, Md.</u>
24. FUNERAL DIRECTOR <u>G. Truman Schwab</u>		25a REC'D BY REGISTRAR <u>MAY 16 1966</u>	
ADDRESS <u>21229 Frederick Ave. Balto. Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>6 1/2 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore #24</b> d. STREET ADDRESS <b>3409 Harmony Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>JOHN ROBERT SCHINDLER</b>						4. DATE OF DEATH <b>5 9 1966</b>		5. SEX <b>M</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH <b>11.21.1909</b>						9. AGE (In years last birthday) <b>56</b> yrs.		10. UNDER 1 YEAR Months <b>5</b> Days <b>9</b>		11. UNDER 24 HRS. Hours <b>11</b> Min. <b>24</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paperbaler</b>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>THOMAS SCHINDLER</b>						14. MOTHER'S MAIDEN NAME <b>MARTHA BENDER</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>021-14-7418</b>		17. INFORMANT <b>Hosp. records, Mt. Wilson State Hospital</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary fibrosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>26 hrs</b>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)												
21. I certify that (I) (this hospital) attended the deceased from <b>10.27</b> , 1965 to <b>5.9</b> , 1966, that (I) (we) last saw the deceased alive on <b>5.9</b> , 1966, and that death occurred at <b>9:40</b> from the causes and on the date stated above.												
22a. SIGNATURE <b>Wm. Newcomer</b>						22b. DATE SIGNED <b>5.9.1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>				
22d. ADDRESS <b>Mount Wilson, Maryland</b>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>5-13-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEM.</b>			23d. LOCATION (City, town or county) (State) <b>7225 EASTERN BLVD. BALTO., CO., MD.</b>				
24. FUNERAL DIRECTOR <b>Charles A. Jule</b>						25a. REC'D BY REGISTRAR <b>MAY 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jule</b>				



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

66646

## CERTIFICATE OF DEATH

66640

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>66 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>ROUTE 1, BOX #289, SOLLY ROAD</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>E.</b> Last <b>SCHMIDT</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>20</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 20, 1891</b>
9. AGE (In years last birthday) yrs <b>75</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT MARINE</b>		10b. KIND OF BUSINESS OR IND. STRY <b>SHIPPING</b>	11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN SCHMIDT</b>	
14. MOTHER'S MAIDEN NAME <b>AMELIA WOCKENFUSS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>	
16. SOCIAL SECURITY NO <b>213 10 84 30</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONIA, UNDETERMINED ORGANISM</b> DUE TO (b) <b>—</b> DUE TO (c) <b>TUMOR, RIGHT LUNG, UNSPECIFIED TYPE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>3/15/66</b> , 19 <b>66</b> , to <b>5/20/66</b> , 19 <b>66</b> , that (X) (we) last saw the deceased alive on <b>5/20/66</b> , 19 <b>66</b> , and that death occurred at <b>4:30A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Heilon Neilson M.D.</b>		22b. DATE SIGNED <b>5/20/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILON NEILSON, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5-23-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>227</b>		25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>PATAPSCO ST. BALTIMORE, MD.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. In please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06647 CERTIFICATE OF DEATH 06641									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>7 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Ridgeway Manor Convalescent Home</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>827 S. 50 th St. 21222</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>DOROTHEA</b> Middle <b>SCHRIEFER</b> Last <b>SCHRIEFER</b>			4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>1966</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 4 - 1885</b>		9. AGE (In years last birthday) <b>81</b> (F UNDER 1 YEAR) (F UNDER 24 HRS. Months Days Hours Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Hillmer</b>					14. MOTHER'S MAIDEN NAME <b>Marie Lang</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Daughter, Mrs. Alma Jung, # 2, a, b, c, d.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic Cardio Vasc. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with Grade IV decompensation</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>April 27, 1966</b> , to <b>May 6, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 6, 1966</b> , and that death occurred at <b>7:50 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Harry L. Knipp</b>					22b. DATE SIGNED <b>May 9 - 1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>Harry L. Knipp M.D.</b>					22d. ADDRESS <b>4116 Edmondson Ave. Balto. Md. 21229</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 10-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>			23d. LOCATION (City, town or county) (State) <b>Dundalk, Maryland 21224</b>		
24. FUNERAL DIRECTOR ADDRESS <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>					25a. REC'D BY REGISTRAR <b>MAY 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

FOR STATE  
HEALTH DEPT.

06648

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06642

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) <b>6853 QUEENS FERRY ROAD</b>		d. STREET ADDRESS <b>5853 Queens Ferry Rd</b>	
3. NAME OF DECEASED (Type or print) <b>David</b> First Middle Last <b>SCHUNICK</b>		4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>58</b>
9. AGE (in years last birthday) <b>58</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CITY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PUBLIC WORKS</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ISRAEL SCHUNICK</b>		14. MOTHER'S MAIDEN NAME <b>ETHEL PETASKY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>215-07-3931</b>	
17. INFORMANT <b>MRS. ALMETA SCHUNICK, 6853 QUEENS FERRY ROAD</b>		Address	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED Where <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>WERNER U. SPITZ, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>5.28.66</b>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 30, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL</b>		23d. LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN</b>		ADDRESS <b>Rd.</b>	
25a. JUDICIAL REGISTRATION <b>JUN 6 1966</b>		25b. JUDICIAL REGISTRATION <b>Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CG649

CERTIFICATE OF DEATH

CG643

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>7</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Balto. Co. Gen. Hospital</u>				d. STREET ADDRESS <u>8033 Windyate CT</u>			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>Schwartzman</u> Last <u>MAN</u>				4. DATE OF DEATH Month <u>5</u> Day <u>5</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-1892</u>		9. AGE (in years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn N.Y.</u>	
13. FATHER'S NAME <u>ABRAHAM SCHWARTZMAN</u>				14. MOTHER'S MAIDEN NAME <u>FANNY MERIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Generalized arteriosclerosis</u> (c) _____ DUE TO _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-5-</u> , 19 <u>66</u> , to <u>5-5-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-5-</u> , 19 <u>66</u> , and that death occurred at <u>4</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Bernardo G. Cabuy</u>				22b. DATE SIGNED <u>5-5-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Bernardo G. Cabuy</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>MAY 6, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HEBREW FRIENDSHIP</u>	
24. FUNERAL DIRECTOR <u>SYLOAN'S LEWIS &amp; SON, INC - 3379 OLYMPIA AVE</u>				25a. REC'D BY REGISTRAR <u>MAY 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>905 Southerly Road</u>						d. STREET ADDRESS <u>905 Southerly Road</u>					
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>E.</u> Last <u>Scrivnor</u>						4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 25, 1887</u>		9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard-retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Black &amp; Decker</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll County</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Lewis Scrivnor</u>						14. MOTHER'S MAIDEN NAME <u>Unknown-dec'd</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-10-9549</u>		17. INFORMANT <u>Family records</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Failure, Chr.</u> DUE TO (b) <u>Post Coronary disease</u> DUE TO (c) <u>Arterio Sclerotic C-V Disease</u> CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1944</u> , 19 <u>  </u> to <u>date</u> , 19 <u>  </u> , that (I)-(we) last saw the deceased alive on <u>4/27</u> , 19 <u>66</u> , and that death occurred at <u>5</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Jos. F. Sedlack</u>											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <u>Jos. F. SEDLACK</u>						22d. ADDRESS <u>200 W. Power Ave Towson</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5-19-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Towson 4, Md.</u>		
24. FUNERAL DIRECTOR <u>John Burns Sons</u>						ADDRESS <u>Towson 4, Md.</u>			25a. REC'D BY REGISTRAR <u>Charles Judge</u>		
						DATE <u>MAY 23 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

\* F.N. 5/17/66



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21220 - TCT. 16</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTO. MEDICAL CENTER</u>					d. STREET ADDRESS <u>Box 397 A</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>SELVEY</u>		4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1966</u>							
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-17-66</u>	9. AGE (In years last birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DADE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore TOWSON, MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Bernard Selvey</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Lucille Floyd</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>N.B.</u>		17. INFORMANT <u>New Born</u>		Address <u>Chart (Infant Birth Information)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Venemia; Suspected congenital heart.</u> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1966</u> to <u>May 19, 1966</u> ; that (I) (we) last saw the deceased alive on <u>May 19, 1966</u> , and that death occurred at <u>2:05 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Pacita D. Tan</u> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>May 20, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>PACITA D. TAN</u>					22d. ADDRESS <u>GBMC, 6701 N. CHARLES RD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 21, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DULANEY VALLEY MEMORIAL</u>			23d. LOCATION (City, town or county) (State) <u>ROCKEYSVILLE, MD.</u>		
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>					25a. REC'D BY REGISTRAR <u>DATE MAY 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



FOR STATE  
HEALTH DEPT.

M

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06652

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06646

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Rural)</b>		c. LENGTH OF STAY IN lb <b>Baltimore - Rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1934 E. Joppa Road</b>		e. STREET ADDRESS <b>1934 E. Joppa Road</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>ROBERT RICHARD SHIVELY Sr.</b>		4 DATE OF DEATH Month Day Year <b>May 27 19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 13, 1909.</b>
9 AGE (In years last birthday) <b>57 yrs</b>		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Transfer Co.</b>	
11 BIRTHPLACE (State or foreign country) <b>Penna</b>		12 CITIZEN OF WHAT COUNTRY <b>USA</b>	
13 FATHER'S NAME <b>John Shively</b>		14. MOTHER'S MAIDEN NAME <b>Lilly Fox</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If Yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>230-01-7206</b>	
17 INFORMANT <b>Mrs. Bessie Shively</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>9731 IMMEDIATE CAUSE (a) Asphyxia</b> DUE TO <b>carbon monoxide poisoning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Inhalation of exhaust fumes</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>5-27 19 66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <b>Baltimore Balto Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Rudiger Breiteneker, M.D.</b>		22. DATE SIGNED <b>5/27/66</b>	
EXAMINER'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/31/66.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24 FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>MAY 31 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06653

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06647

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>21218</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1202 E. 36th St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Albert E. Sikorsky M.D.</b>		4. DATE OF DEATH Month Day Year <b>May 31 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-19-03</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. UNDER 1 YEAR Months Days <b>62</b>	11. UNDER 24 HRS. Hours Min. <b>62</b>
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>John Sikorsky</b>		14. MOTHER'S MAIDEN NAME <b>Carolina Miko</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>220-44-0984</b>		16. SOCIAL SECURITY NO. <b>220-44-0984</b>	
17. INFORMANT <b>Lorraine Chlad Sikorsky, wife, above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent Bleeding Esophageal Varices</b> DUE TO (b) <b>Liver Cirrhosis</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 22, 1966</b> to <b>May 31, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 31, 1966</b> , and that death occurred at <b>3:05 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Ramon P. Lopez</b>		22b. DATE SIGNED <b>May 31, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ramon P. Lopez</b>		22d. ADDRESS <b>7620 York Road 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/3/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		25a. REC'D BY REGISTRAR <b>JUN 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06648

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MONKTON</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MONKTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELLEN SIMON</u>		4. DATE OF DEATH Month Day Year <u>MAY 22 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Detroit, Mich..</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Sharpless</u>		14. MOTHER'S MAIDEN NAME <u>Lorraine Wav</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARBON MONOXIDE POISONING</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5-23-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>of Md. Med. School</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
Medical Examiner Office		25b. REGISTRAR'S SIGNATURE	
		DATE <u>MAY 25 1966</u> <u>Charles Yunge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO MEDICAL EXAMINER: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 06649

1. PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - 24</b>	c. LENGTH OF STAY IN 1b <b>life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - 24</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7302 Kirtley Rd</b>		d. STREET ADDRESS <b>7302 Kirtley Rd</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>R.</b> Last <b>Skinner</b>		4. DATE OF DEATH Month <b>5</b> Day <b>8</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>II-14-1932</b>
9. AGE (In years last birthday) yrs <b>33</b>		10. IF UNDER 1 YEAR Months <b>33</b>	10. IF UNDER 24 HRS Days <b>33</b> Hours <b>33</b> Min. <b>33</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grevey-Grady</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>		13. FATHER'S NAME <b>Robert J. Skinner</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Meisel</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Koren U S A</b>	
16. SOCIAL SECURITY NO <b>213-30-5590</b>		17. INFORMANT <b>Barbara Skinner 7302 Kirtley Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Heart &amp; Pancreas</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f (City or town) (County) (State)</b>
21. I certify that I attended the deceased from <b>Nov 1, 1965</b> to <b>May 1966</b> , that I last saw the deceased alive on <b>April 25, 1966</b> , and that death occurred at <b>7:10 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Manuel P. De Leon</b>		ADDRESS (Street, city or town, state) <b>2840 Eastern Ave</b>	
PHYSICIAN'S NAME (Type) <b>MANUEL P. DE LEON</b>		DATE SIGNED <b>5/9/66</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-12-66</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gardens Of Faith</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Dabowski 1005 Dunstable Ave.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 11 1966</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

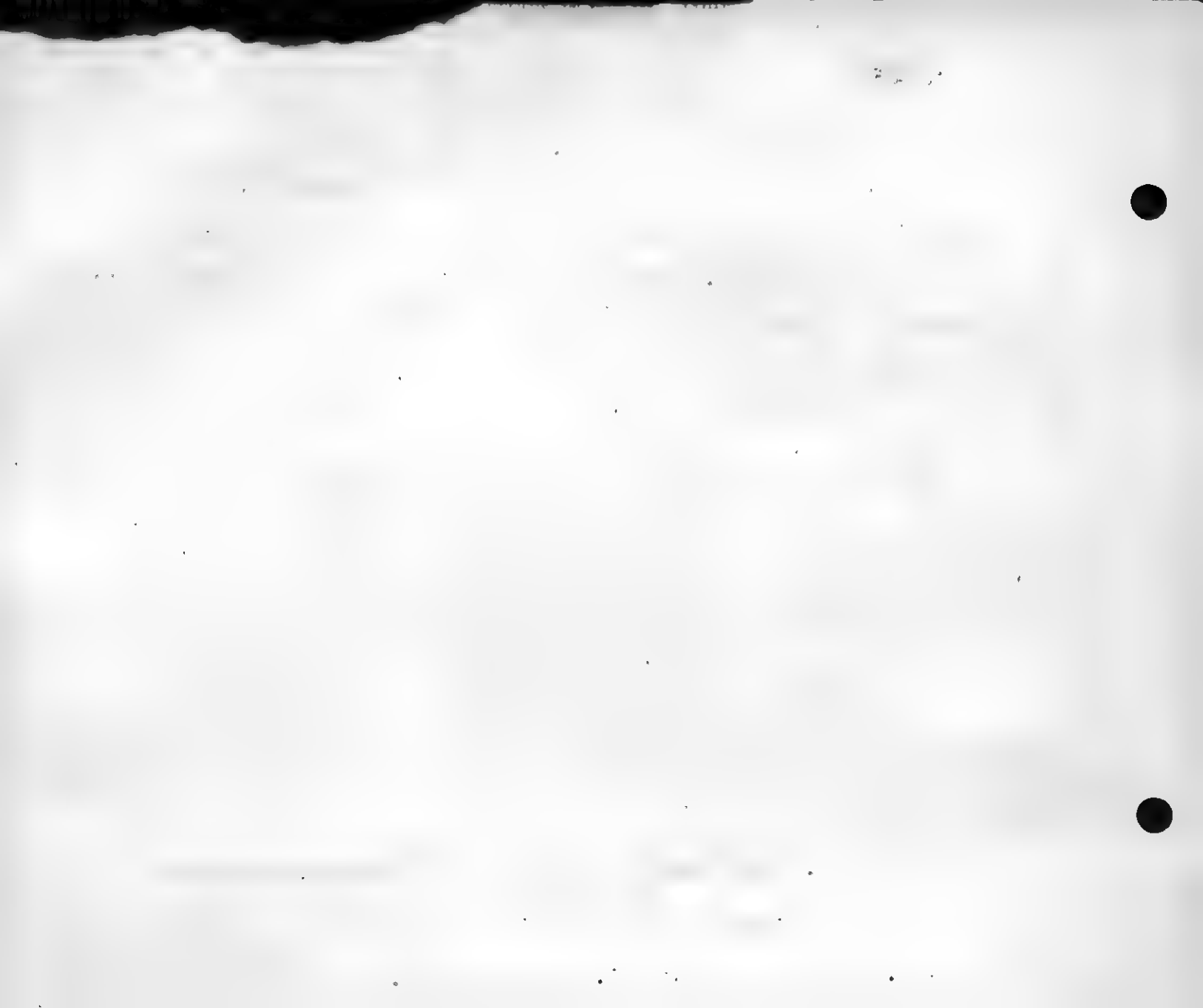
M

MARYLAND STATE DEPARTMENT  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06656

06650

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTA</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LUTHERVILLE</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>1418 Burton Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Forest Haven Convalescent Home</u>			
3. NAME OF DECEASED (Type or print) <u>Teresa A. Sloan</u>		4. DATE OF DEATH <u>May 19th., 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 21, 1869</u>
9. AGE (In years last birthday) <u>96</u>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Peter Haydock</u>		14. MOTHER'S MAIDEN NAME <u>Christina ??</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs R. Franklin</u>		Address <u>1418 Burton Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC ON AORTA - VASCULAR DISEASE</u> DUE TO (c) <u>8 PULMONARY EMBOLI</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>65</u> , to <u>5/19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/19</u> , 19 <u>66</u> , and that death occurred at <u>7:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Shaw</u>		22b. DATE SIGNED <u>5/20/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John Shaw</u>		22d. ADDRESS <u>5800 Edmondson Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/23/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		23d. LOCATION (City, town or county) (State) <u>BALTO., MD. - 21229</u>	
24. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u>		25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in transit within 72 hours after death.

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6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

CS657

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1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>213 Courtland Avenue</u>		e STREET ADDRESS <u>213 Courtland Avenue</u>	
3 NAME OF DECEASED (Type or print) <u>Frank</u> First Middle Last <u>Sluis</u>		4 DATE OF DEATH <u>May 12, 1966</u> Month Day Year 19	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>March 27, 1889</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	9 AGE (In years last birthday) yrs. <u>77</u>
11 BIRTHPLACE (State or foreign country) <u>Utrecht, Holland</u>		12 CITIZEN OF WHAT COUNTRY? <u>Holland</u>	
13 FATHER'S NAME <u>Cysbert Sluis</u>		14 MOTHER'S MAIDEN NAME <u>Sophia Vander Tol</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>219-10-4503</u>	
17 INFORMANT <u>Personal Records</u>		Address	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Sudden</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles J. Judge</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>May 16, 1966</u>	
24 FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a NAME OF CEMETERY OR CREMATORY <u>Jessons Cemetery</u>	
25b LOCATION (City or town) (County) (State) <u>Cockeysville, Maryland</u>		25c REC'D BY REGISTRAR <u>May 17 1966</u>	
25d REC'D BY REGISTRAR <u>Charles Judge</u>		25e REC'D BY REGISTRAR	

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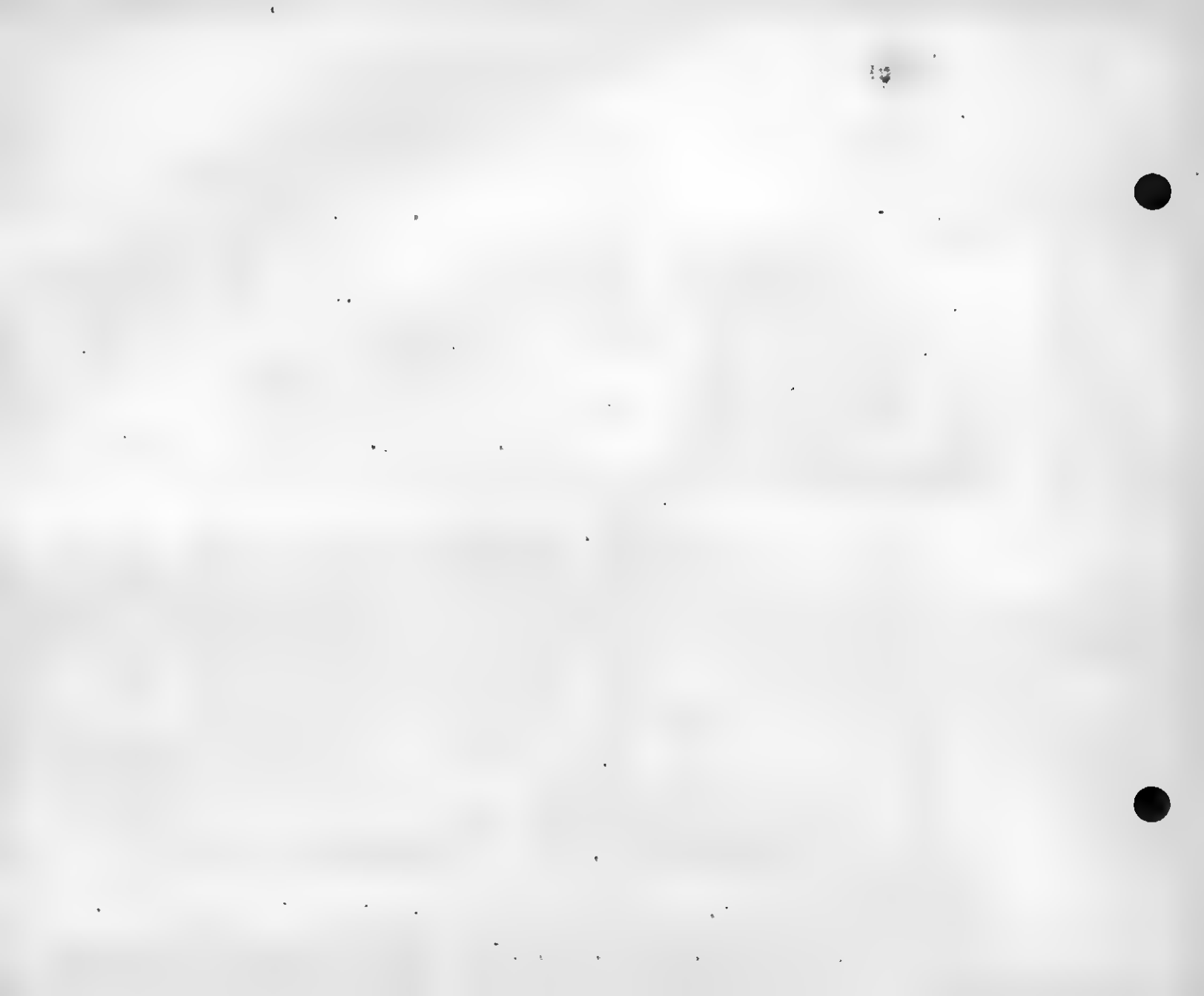


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21224</b> d. STREET ADDRESS <b>512 S. Conkling St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Catherine Elizabeth Smith</b>			4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>19 66</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 27, 1906</b>		9. AGE (In years last birthday) <b>60</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Ambrose Miller</b>					14. MOTHER'S MAIDEN NAME <b>Anne Ship Hipshman</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Mr. Louis J. Smith</b>			Address <b>(Same)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia, right lobe.</b> 1930 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Metastatic carcinoma of the brain.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>April 24, 1966</b> , to <b>May 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 27, 1966</b> , and that death occurred at <b>7:20 M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>D.R. Govinda Rao, M.D.</b>					22b. DATE SIGNED <b>May 27, 1966</b>			22c. PHYSICIAN'S NAME (Type) <b>D.R. Govinda Rao, M.D.</b>	
22d. ADDRESS <b>7620 York Rd., Baltimore, Maryland 21204</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/31/66.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>					25a. REC'D BY REGISTRAR <b>MAY 31 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				d. STREET ADDRESS <u>1329 Sulphur Spring Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1329 Sulphur Spring Rd</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>James W. Smith, Sr.</u>						4. DATE OF DEATH <u>May 20</u> 19 <u>66</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/25/44</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gas &amp; Electric Co</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Smith</u>						14. MOTHER'S MAIDEN NAME <u>Bessie Burgess</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.I.</u>				16. SOCIAL SECURITY NO. <u>212-05-7115</u>		17. INFORMANT <u>Lillian V. Smith</u> Address <u>1329 Sulphur Sp. Rd</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusive myocardial infarction</u> 4-2-1 DUE TO (b) <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>NOT</u> , 19 <u>63</u> , to <u>5-20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-20</u> 19 <u>66</u> , and that death occurred at <u>1:30</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Pearl Pass</u>						22b. DATE SIGNED <u>5-21-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Pearl Pass</u>						22d. ADDRESS <u>4001 Wilkens Ave.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/23/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR <u>Andrew M. 1329 Sulphur Sp Rd</u>						25a. REC'D BY REGISTRAR <u>MAY 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY in 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		d. STREET ADDRESS <u>9615 10th Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Rickie</u> Last <u>Smith</u>		4 DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>19 66.</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct. 4, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9 AGE (in years last birthday) <u>74</u> yrs
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Davis</u>		14. MOTHER'S MAIDEN NAME <u>Rickie ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-16-7241</u>	
17. INFORMANT <u>John D. Hock : 9615 10th Ave. Balto., Md.</u>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Sudden</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		22. DATE SIGNED <u>5/9/66</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5-12-66.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moneland Memorial Park</u>	23d. LOCATION (City or town) (County) (State) <u>2901 Taylor Ave. Ba. Co., Md.</u>
24. FUNERAL DIRECTOR <u>Charles S. Gailor, Balto., Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 12 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

(M)

06662

CERTIFICATE OF DEATH

06655

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN b. <b>7 yrs.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		d. STREET ADDRESS <b>7507 Knollwood Rd. 21204</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Milton E. Smith</b>			4. DATE OF DEATH <b>May 8 19 66</b>			5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 9, 1892</b>		9. AGE (In years lost birthday) <b>73</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Omega, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>A. J. Smith</b>			14. MOTHER'S MAIDEN NAME <b>Phoebe Vance</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W. 1</b>		16. SOCIAL SECURITY NO. <b>215-05-2965</b>		17. INFORMANT <b>Mrs. Milton E. Smith</b>		Address <b>7507 Knollwood Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>+201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary occlusion</b> DUE TO (c) <b>Hypertensive arteriosclerotic cardiovascular disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-18</b> , 19 <b>58</b> , to <b>5-8</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-10</b> 19 <b>66</b> , and that death occurred at <b>3 A</b> M, from causes and on the date stated above.									
22a. SIGNATURE <b>Alfred G. Ossman Jr.</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5-10-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Alfred G. Ossman Jr.</b>				22d. ADDRESS <b>1010 St. Paul St.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-11-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson Inc.</b>				ADDRESS <b>1050 York Rd.</b>		25. REGD BY REGISTRAR <b>MAY 13 1966</b>		25a. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
06662 CERTIFICATE OF DEATH 06656

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> c. LENGTH OF STAY IN 1b <i>all of life</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greater Baltimore Med Center</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Timonium</i> d. STREET ADDRESS <i>27 Baymont Rd</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <del>SMITH</del> <i>ROY PERCY SMITH</i> First Middle Last 4. DATE OF DEATH <i>MAY 31 1966</i> Month Day Year				5. SEX <i>M</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>4-30-99</i> 9. AGE (In years last birthday) <i>67</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED (night watchman)</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Balto. Co.</i> 11. BIRTHPLACE (County & State, or foreign country) <i>Sunnybrook, Md.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				13. FATHER'S NAME <i>Charles Smith</i> 14. MOTHER'S MAIDEN NAME <i>Laura Carmichael</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <i>?</i> 17. INFORMANT <i>Wife</i> Address				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> DUE TO (b) <i>Squamous cell carcinoma</i> DUE TO (c) <i>probably primary in lung</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <i>3:05 PM</i> , from the causes and on the date stated above.				22a. SIGNATURE <i>H.T. Voorstad</i> 22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>H.T. VOORSTAD</i> 22d. ADDRESS				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> 23b. DATE THEREOF <i>6-3-66</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley Memorial</i> 23d. LOCATION (City, town or county) (State) <i>Cockeysville, Md.</i>				24. FUNERAL DIRECTOR <i>John Burns Sons</i> ADDRESS <i>Towson, Md.</i> 25. REC'D BY REGISTRAR <i>JUN 2 1966</i> 25a. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>			

100



100



## CERTIFICATE OF DEATH

CS663

C6657

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, give rural route and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville #34</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8007 Harris Ave.</b>		d. STREET ADDRESS <b>8007 Harris Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Edna Snyder</b>		4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>19 66</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1886</b>
9. AGE (In years last birthday) yrs <b>79</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>17</b> Hours <b>17</b> Min <b>17</b>	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>Warren, Pa.</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Thomas Tyler</b>		16. MOTHER'S MAIDEN NAME <b>Unknown</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO	
19. INFORMANT <b>Mrs. Florence Crawford</b>		Address <b>8007 Harris Ave.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>GENERALIZED ARTERIO SCLEROSIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden 8 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/22/64</b> to <b>5/17, 1966</b> that (I) (we) last saw the deceased alive on <b>5/17</b> 19 <b>66</b> , and that death occurred at <b>1 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Leonard P. Berger</b>		22b. DATE SIGNED <b>5/17/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leonard P. Berger</b>		22d. ADDRESS <b>8100 HARTFORD RD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>5/20/66.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>MAY 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

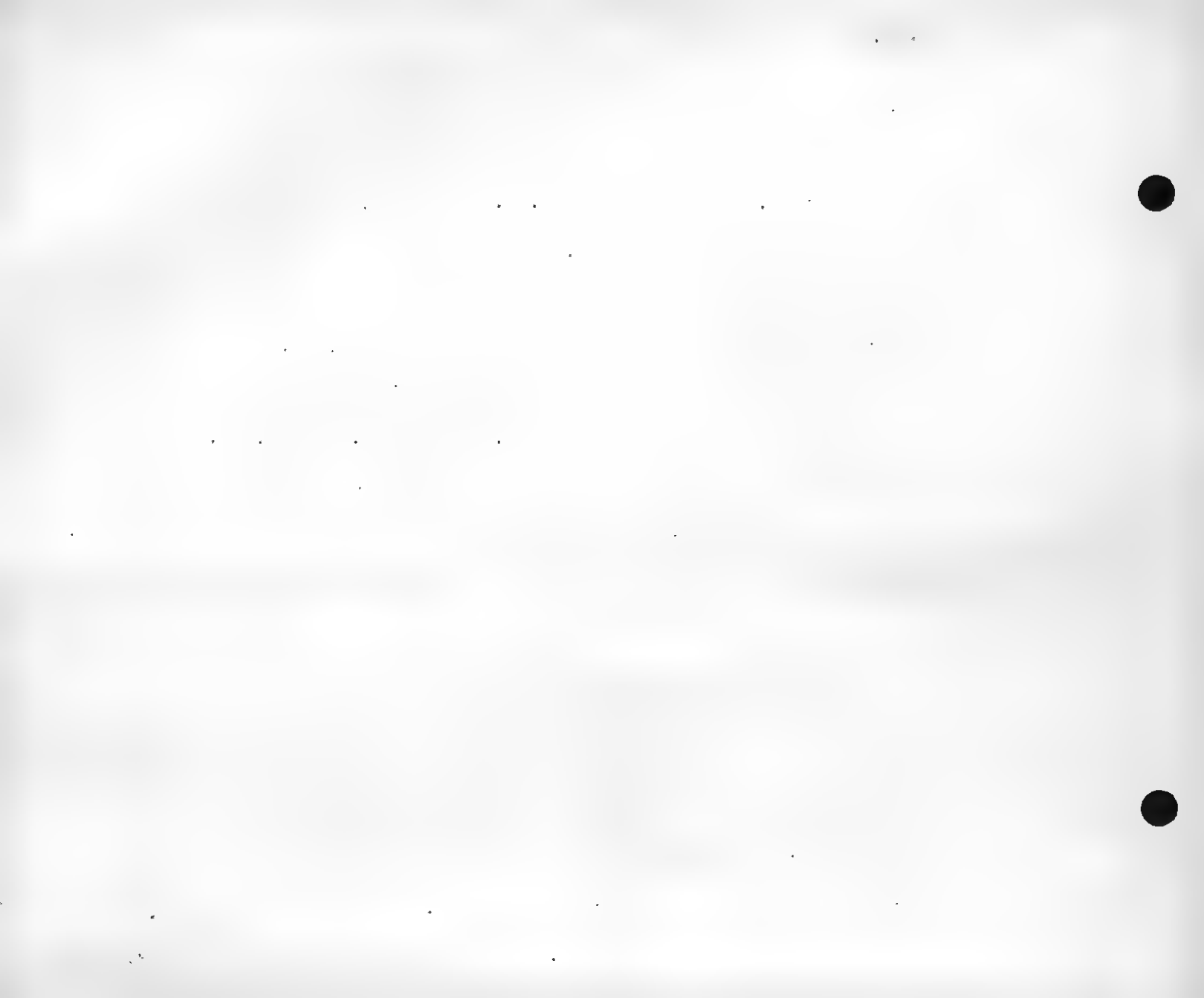


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>509 East Joppa Rd. Chesapeake Manor N. H.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>5600 Loch Raven Boulevard</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>K.</b> Last <b>Snyder</b>			4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>1966</b>			5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <b>May 11, 1894</b>			9. AGE (In years last birthday) <b>71</b> yrs.			IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min.			IF UNDER 24 HRS. Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>				12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>? Schneider</b>						14. MOTHER'S MAIDEN NAME <b>?</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Mr. Chester Wm. Snyder, Jr.</b> Address <b>same address</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANEURYSM OF THE THORACIC AORTA</b> 401X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 15, 1964</b> to <b>MAY 2, 1966</b> , that (I) (we) last saw the deceased alive on <b>MAY 2, 1966</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.																	
22a. SIGNATURE <b>Louis V. Elias, M.D.</b>						22b. DATE SIGNED <b>MAY 3, 1966</b>											
22c. PHYSICIAN'S NAME (Type) <b>LUIS V. ELIAS, M.D.</b>						22d. ADDRESS <b>1701 MERIDENE DR.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>5/4/1966</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Pikesville, Md.</b>					
24. FUNERAL DIRECTOR <b>Wm. J. Tiekner &amp; Sons north 2nd Ave.</b>						25. REC'D BY REGISTRAR <b>MAY 3 1966</b>						25b. REGISTRAR'S SIGNATURE <b>Wm. J. Tiekner</b>					





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

06665

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06659

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Old Hanover Road</b>		d. STREET ADDRESS <b>2000 Orleans Street</b>	
3 NAME OF DECEASED (Type or print) <b>Cesper</b>		4 DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Colored</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Apr. 24, 1941</b>
9 AGE (In years, last birthday) <b>25</b> yrs		10 IF UNDER 1 YEAR Months <b>25</b> Days <b>29</b> Hours <b>19</b> Min <b>66</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Virginia</b>		12 CITIZENSHIP OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Melvin Spence</b>		14. MOTHER'S MAIDEN NAME <b>Velma Reid</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>284-38-6060</b>	
17 INFORMANT <b>Mrs. Velma Spence</b>		Address <b>Baltimore, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per part. Death was caused by IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <b>Out on lake in rowboat, fell overboard &amp; drowned.</b>	
20c TIME OF INJURY Month, Day, Year <b>Est. 5 pm May 29 1966</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Lake</b>	20f. (City or town) (County) (State) <b>Reisterstown Balto. Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.,</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
6 Hanover Rd. Reisterstown, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>6/2/66</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Garden of Eternal Hope</b>		23d LOCATION (City or Town) (County) (State) <b>Carroll Co. Md.</b>	
24 FUNERAL DIRECTOR <b>Law Funeral Home</b>		25a REC'D BY REGISTRAR <b>JUN 2 1966</b>	
802 Madison Ave. Balto. Md.		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

CS666

06660

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baldwin</b> c. LENGTH OF STAY IN 1b <b>Baldwin</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Brooks Cross Farm</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baldwin</b> d. STREET ADDRESS <b>Brooks Cross Farm</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank</b> First Middle Last		4. DATE OF DEATH <b>Spring 5/10 1966</b> Month Day Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/8/86</b>
9. AGE (In years last birthday) <b>80</b> rs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	11. BIRTHPLACE (County & State, or foreign country) <b>England</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Ruben Spring</b>	
14. MOTHER'S MAIDEN NAME <b>?</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>212-32-1769</b>		17. INFORMANT <b>Mr. Frank Spring, Jr.</b> Address <b>28 Oakway Road Timonium, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>none.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>none</b> 19 p.m. <b>none</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... <b>8/31 1965</b> to <b>5/10 1966</b> , that (I) <b>also</b> saw the deceased alive on... <b>4/25 1966</b> , and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>James F. White, Jr. M.D.</b>		22b. DATE SIGNED <b>5/11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>James F. White, Jr. M.D.</b>		22d. ADDRESS <b>Tarrettsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 13, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION (City, town or county) (State) <b>Cockeysville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Brooks Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 16 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>104 Kingston Park Road</u>					d. STREET ADDRESS <u>104 Kingston Park Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Adele</u> Last <u>Stissel</u>		4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1966</u>							
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1901</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John D. Lutjerath</u>					14. MOTHER'S MAIDEN NAME <u>Blanche E. Walters</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Mrs Carol Ann Stevans</u>		Address <u>Joppa, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary &amp; Cerebrovascular</u> <u>1538</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>57</u> , to <u>May</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 24</u> 19 <u>66</u> , and that death occurred at <u>1248</u> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert J. Lyden</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>ROBERT J. LYDEN, MD</u>					22d. ADDRESS <u>6402 GORDEN RIVER RD. BALTO</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>5-31-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>						25a. REC'D BY REGISTRAR <u>MAY 31 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
06668  
06662  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>Baltimore 21221</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>1713 Earhart Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Gerald</b> Middle <b>D.</b> Last <b>Stotler, Jr.</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1965</b>
9. AGE (in years last birthday) <b>9</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>9</b> Hours <b>9</b> Min. <b>9</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Gerald D. Stotler</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Wilder</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Parents</b>	
17. INFORMANT <b>(Same)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intussusception with gangrene of the terminal ileum and colon.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 10, 1966</b> , to <b>May 10, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 10, 1966</b> , and that death occurred at <b>2:15 P.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>D.R. Govinda Rao</b>			
22b. DATE SIGNED <b>May 10, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>D.R. Govinda Rao, M.D.</b>			
22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>5/12/66</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>			
23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>J. S. Connelley Sons, 300 N. Main (21)</b>			
25a. REC'D BY REGISTRAR <b>MAY 13 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			





## CERTIFICATE OF DEATH

Reg. Dist. No. 06663

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>5 Mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHANGRI-LA Nursing Home</u>				d. STREET ADDRESS <u>Northwood Apts</u>			
3. NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>M.</u> Last <u>STRECKFUS</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATELY WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-6-1893</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Alexander Brown Co - Eastern Shore, Md</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Jones</u>				14. MOTHER'S MAIDEN NAME <u>Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>229-22-5107</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November</u> , 19 <u>65</u> , to <u>May</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>May 7</u> , 19 <u>66</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Millard T. Traband, Jr.</u>				ADDRESS (Street, city or town, state) <u>5101 Gwynn Oak Avenue, Baltimore, Md. 21207</u>			
DATE SIGNED <u>5/9/66</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-10-66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ELLsworth Armacost</u>				ADDRESS <u>4600 Liberty Hgts Ave</u>			
24a. REC'D BY REGISTRAR <u>John J. Judge</u>				24b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>			
DATE <u>MAY 10 1966</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

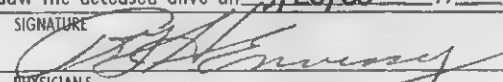

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
06670					CERTIFICATE OF DEATH					06664				
1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>8 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>					d. STREET ADDRESS <b>2317 DUKELAND ST.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3 NAME OF DECEASED (Type or print) First Middle Last <b>JULIUS SULLIVAN</b>					4 DATE OF DEATH Month Day Year <b>MAY 19 19 66</b>									
5 SEX <b>MALE</b>		6 COLOR OR RACE <b>NEGRO</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>OCTOBER 10, 1919</b>		9 AGE (In years last birthday) <b>46 yrs.</b>		10 IF UNDER 1 YEAR Months Days		11 IF UNDER 24 HRS Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEVEDORE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SHIPPING</b>		11 BIRTHPLACE (County & State, or foreign country) <b>BRANCHVILLE, S.C.</b>				12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13. FATHER'S NAME <b>JULIUS SULLIVAN (DEC)</b>					14. MOTHER'S MAIDEN NAME <b>CHRISTOBELL WILSON (DEC)</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>214 16 84 80</b>		17. INFORMANT <b>VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND</b>										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN STEM FAILURE</b> DUE TO (b) <b>CEREBRAL SWELLING</b> DUE TO (c) <b>SARCOMA OF THE BRAIN</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>5/12/66</b> , 19 <b>66</b> , to <b>5/20/66</b> , 19 <b>66</b> , that <del>it</del> (we) last saw the deceased alive on <b>5/20/66</b> , 19 <b>66</b> , and that death occurred at <b>10:40 PM</b> , from causes and on the date stated above.														
22a. SIGNATURE 					M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>5/20/66</b>						
22c. PHYSICIAN'S NAME (Type) <b>ROBERT G. HENNESSY, M. D.</b>					22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-23-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>							
24. FUNERAL DIRECTOR <b>MORTEN &amp; DYETTE FUNERAL HOME</b> ADDRESS <b>1701 Laurens St. Baltimore, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>MAY 24 1966</b>		25b. REGISTRAR'S SIGNATURE 							



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

06671

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06665

1 PLACE OF DEATH a COUNTY <b>Baltimore</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b>		b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b>		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d STREET ADDRESS <b>230 N. Mount St.</b>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Robert Earl Sutton</b>		4 DATE OF DEATH Month Day Year <b>5 16 19 66</b>			
5 SEX <b>male</b>	6 COLOR OR RACE <b>colored</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12/30/1944</b>	9 AGE (in years last birthday) <b>21</b> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13 FATHER'S NAME <b>Fred D. Sutton</b>		14 MOTHER'S MAIDEN NAME <b>Willie Lee Thompson</b>		12 CITIZEN OF WHAT COUNTRY?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>217-40-2535</b>		17 INFORMANT <b>Martha M. Sutton</b> Address <b>Same</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>9294</b> IMMEDIATE CAUSE (a) <b>Presumably drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>? - found in pool (School)</b>			
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>5 16 1966</b>		20d INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <b>water</b>		20f (City or town) (County) (State) <b>Baltimore-rural Balto. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Werner H. Spitz</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>5/17/66</b>	
EXAMINER'S NAME (Type) <b>Werner H. Spitz, M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>5/20/66</b>		23c NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	
24. FUNERAL DIRECTOR <b>Aslington S. Phillips</b>		ADDRESS <b>172 N. Mount St.</b>		25a REC'D BY REGISTRAR <b>MAY 20 1966</b>	
				25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06672

06666

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE - 21222</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>7009 RAILWAY AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>JOHN W. TAYLOR</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>MAY 3 19 66</b>			
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>JULY 30, 1885</b>	
<b>9. AGE</b> (In years last birthday) yrs <b>80</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>ENGINEER (SHIP)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>MERCHANT MARINE</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>BALTIMORE COUNTY, MARYLAND U.S.A.</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME</b> <b>JAMES G. TAYLOR</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>MARGARET GROSS</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>			
<b>16. SOCIAL SECURITY NO</b> <b>215 50 64 92</b>				<b>17. INFORMANT</b> Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>THROMBOSIS OF THE RIGHT MIDDLE CEREBRAL ARTERY</b> DUE TO <b>552X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____							INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. p.m. _____ 19____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg, etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that</b> <del>the</del> (this hospital) attended the deceased from <b>4/29/66</b> , 19____, to <b>5/3/66</b> , 19____, that <del>it</del> (we) last saw the deceased alive on <b>5/3/66</b> , 19____, and that death occurred at <b>5:35AM</b> , from causes and on the date stated above.							
<b>22a. SIGNATURE</b> <i>Lawrence F. Awalt, Jr.</i>				<b>22b. DATE SIGNED</b> <b>5/3/66</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>LAWRENCE F. AWALT, JR., M. D.</b>	
<b>22d. ADDRESS</b> <b>VAH FORT HOWARD, MARYLAND</b>				<b>22e. REC'D BY REGISTRAR</b> <b>DATE</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>5/6/1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>GREEN GURCH CEMETERY</b>		<b>23d. LOCATION (City or town) (County) (State)</b> <b>GREEN GURCH, MARYLAND</b>	
<b>24. FUNERAL DIRECTOR</b> <i>Walter Brooks Bradley</i>				<b>25a. REGISTRAR'S SIGNATURE</b> <i>Walter Brooks Bradley</i>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>	

2102



CERTIFICATE OF DEATH

066673

06667

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>33 Butler Road</b>				d. STREET ADDRESS <b>33 Butler Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>M.</b> Last <b>Taylor</b>				4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 30, 1905</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	IF UNDER 24 HRS. Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employed in Laundry at Rosewood Hospt.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Carroll Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Roy E. Griswold</b>				14. MOTHER'S MAIDEN NAME <b>Susan Chafer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-1057</b>		17. INFORMANT <b>Mr. Homer N. Taylor</b> Address <b>Glyndon, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident - thrombosis</b> DUE TO (b) <b>Diabetes Mellitus - severe</b> DUE TO (c) <b>Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>3 months</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 21, 1966</b> to <b>May 25, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 19, 1966</b> , and that death occurred at <b>11:57 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles E. McWilliams</b>				22b. DATE SIGNED <b>5-26-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Reisterstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>'Old Oakland Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Sykesville, Md.</b>	
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>				25a. REC'D BY REGISTRAR <b>MAY 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

08674

06668

Items 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MIDDLE RIVER</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>107 RIVERTHORNE RD.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MIDDLE RIVER</b> d. STREET ADDRESS <b>107 RIVERTHORNE RD.</b>	
3. NAME OF DECEASED (Type or print) <b>STANISLAUS</b> First Middle Last 4. DATE OF DEATH <b>MAY 27 1966</b> Month Day Year		5. SEX <b>M</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>11/1/1886</b> 9. AGE (In years last birthday) <b>80</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BETH. STEEL</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>POLAND</b> 11. BIRTHPLACE (County & State, or foreign country) <b>USA</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>PETER TELAK</b> 14. MOTHER'S MAIDEN NAME <b>JARZWINSKI</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> 16. SOCIAL SECURITY NO. <b>217-01-3356</b> 17. INFORMANT <b>CASIMIR TELAK 1601 WEYBURN RD</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>6/29, 1964</b> to <b>5/27, 1966</b> ; that (I) (we) last saw the deceased alive on <b>5/27, 1966</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>M. Castro, Jr.</b> 22c. PHYSICIAN'S NAME (Type) <b>M. CASTRO, JR., M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>805 Fuseage Ave., Balto 20, Md.</b> 22b. DATE SIGNED <b>5/28/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEM</b> 23d. LOCATION (City, town or county) (State) <b>BALTO. MD.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. WEBER &amp; SONS INC., 401 S. CHESTER ST.</b> 25a. REC'D BY REGISTRAR <b>MAY 31 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



**FOR STATE  
HEALTH DEPT**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08675

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08192

1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <b>MD.</b> b COUNTY <b>BALTO.</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c LENGTH OF STAY IN lb <b>2 hrs.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>		e STREET ADDRESS <b>BOX 117A STANBURY MILL RD.</b>	
3 NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>HENRY</b> Last <b>THIELL</b>		4 DATE OF DEATH Month <b>MAY</b> Day <b>29</b> Year <b>1966</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2-1-93</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRINTER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>PRINTING</b>	9 AGE (in years) <b>73</b> yrs
11 BIRTHPLACE (State or foreign country) <b>Perry Hall, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>William C. Thiell</b>		14 MOTHER'S MAIDEN NAME <b>Anna Walter</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes W.W.I</b>		16 SOCIAL SECURITY NO <b>212-10-3790</b>	
17 INFORMANT <b>Mrs. Bertha K. Thiell</b>		Address <b>Box 117A Stanbury Mill Rd. Monroton, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. _____ p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <b>BALTIMORE</b>	
		Address (Street, city, town, or county)	
22a BURIAL (CREMATION, REMOVAL) (Specify)	22b DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d LOCATION (City or town) (County) (State)
<b>BURIAL</b>	<b>JUNE 1, 1966</b>	<b>St. John's Lutheran Cem.</b>	<b>Sweet Air, Maryland</b>
24 FUNERAL DIRECTOR <b>Wm. Cook-Brooks &amp; Towson Inc. 1050 York Rd. 31204</b>		25a REC'D BY REGISTRAR <b>JUN 7 1966</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06676

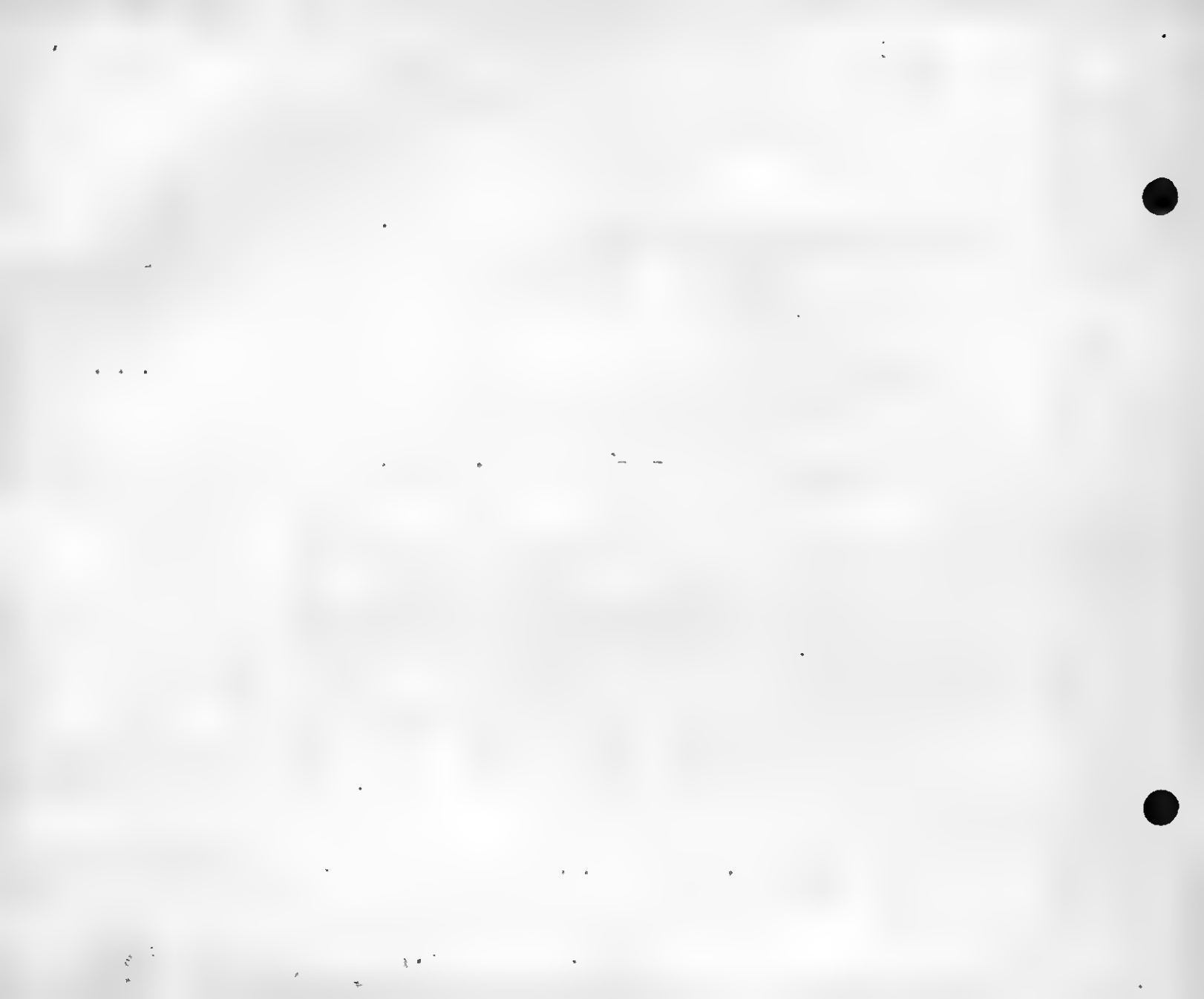
## CERTIFICATE OF DEATH

06669

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN ib <b>2 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2033 N. Washington Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>IRA (NMI) THOMPSON</b>				4. DATE OF DEATH Month Day Year <b>MAY 6TH 19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/19/06</b>	
9. AGE (In years last birthday) <b>60 yrs</b>		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Cannons Cross, Delaware</b>	
12. CIT ZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Joseph Thompson</b>			
14. MOTHER'S MAIDEN NAME <b>Nora Dix</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>			
16. SOCIAL SECURITY NO. <b>221-07-26-82</b>				17. INFORMANT Address <b>Clin. Records, VAH, Fort Howard, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CIRCULATORY COLLAPSE</b> <b>7200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>UREMIA</b>							INTERVA. BETWEEN ONSET AND DEATH <b>MINUTES</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>HEMIPLEGIA, OLD, BOTH SIDES</b>							19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>May 4, 19 66</b> , to <b>May 6, 19 66</b> that (we) last saw the deceased alive on <b>May 6, 19 66</b> , and that death occurred at <b>1:30 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>MUSTAFA H. ADATEPE, M.D.</b>	
22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>LOCKS FUNERAL HOME</b>				25a. REC'D BY REGISTRAR <b>MAY 9 1966</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06677

06670

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b>			c. LENGTH OF STAY IN 1b <b>Life</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-rural</b> /	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>305 Sollers Point Rd.</b>				d. STREET ADDRESS <b>305 Sollers Point Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Angela Johnson Thornhill</b>				4 DATE OF DEATH Month Day Year <b>5 3 19 66</b>			
5 SEX <b>female</b>	6 COLOR OR RACE <b>colored</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>N/A</b> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2-17-1963</b>		9 AGE (In years last birthday) <b>3</b> yrs	F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>JAMES H. Thornhill</b>				14. MOTHER'S MAIDEN NAME <b>MARY JOHNSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Mary Johnson</b> Address <b>120 Center ST.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Second and Third degree burns of the majority of the body surface, associated with smoke and soot inhalation.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>conflagration</b>					
20c. TIME OF INJURY Month, Day, Year Hour of m <b>5:30 xpm 5 3 19 66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Dundalk Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>				22. DATE SIGNED <b>5/3/66</b>			
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-5-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO Md.</b>	
24. FUNERAL DIRECTOR <b>MORTON + DYE - 1701 Laurens ST.</b>				25a. REC'D BY REGISTRAR <b>MAY 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06678

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06671

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pandallstown</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Balto. Co. General</i>		d. STREET ADDRESS <i>4211 Bayonne Ave</i>	
3. NAME OF DECEASED (Type or print) <i>EARL HERBERT THORPE</i>		4. DATE OF DEATH Month <i>May</i> Day <i>21</i> Year <i>1966</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-13-06</i>
9. AGE (In years past birthday) <i>59</i> yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>auto supply</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Wm WILLIAM THORPE</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Stevens</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>216-01-4765</i>	
17. INFORMANT <i>Balto. Co. Gen. Hosp Records</i>		Address <i>Pandallstown</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> 421 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>			19. INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>none</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>J. J. Caples</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>5-25-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>LOUDON PARK CEMETERY</i>	23d. LOCATION (City or Town) (County) (State) <i>BALTO., MARYLAND</i>
24. FUNERAL DIRECTOR <i>HOWARD H. HUBBARD, 4107 WILKENS AVE. BALTO. 29</i>		25a. REC'D BY REGISTRAR <i>MAY 24 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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1 (M)  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 66672

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>621 N. Pittsburg Ave.</u>		d. STREET ADDRESS <u>621 N. Pittsburg Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>De Roy L Thornton</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1964</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1909</u>
9. AGE (in years last birthday) <u>56</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Oxford, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cass Thornton</u>		14. MOTHER'S MAIDEN NAME <u>Annie Bulloch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-07-0994</u>	
17. INFORMANT <u>Lenora T. Mabrey - 621 New Pittsburg Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 47 DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Dundalk Balto md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Theo C. Patterson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>THEO C. PATTERSON</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>5/3/64</u>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-7-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Charles R. Law</u>		ADDRESS <u>802 Madison Ave., Balto., Md.</u>	
25a. REC'D BY REGISTRAR <u>MAY 4 1964</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18, and give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1d	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d STREET ADDRESS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St Josephs Hospital</b>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>THUNE</b> Last <b>THUNE</b>		4 DATE OF DEATH Month <b>5</b> Day <b>27</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8-12-1904</b>
9 AGE (In years birthday) <b>61</b> yrs		10 IF UNDER 1 YEAR Months <b>5</b> Days <b>27</b> Hours <b>19</b> Min <b>66</b>	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hardware Merchant</b>		11b KIND OF BUSINESS OR INDUSTRY <b>Selfemployed</b>	
12 BIRTHPLACE (State or foreign country) <b>Bel Air, Maryland</b>		13 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ernest Thune</b>		14. MOTHER'S MAIDEN NAME <b>Cora Unknown</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16 SOCIAL SECURITY NO <b>214-34-3601</b>	
17 INFORMANT <b>Mrs Hazel I. Thune</b>		Address <b>306 E. Gittings Avenue</b>	
18 CAUSE OF DEATH (Enter on y one cause per PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4221</b> <b>Atherosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>disease</b> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a m <b>9</b> p m	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		22. DATE SIGNED <b>5.28.66</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>5-30-1966</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d LOCATION (City or town) (County) (State) <b>Baltimore, Co. Md.</b>	
24 FUNERAL DIRECTOR <b>Lassalam Funeral Home</b>		ADDRESS <b>2461 Balduin Road</b>	
25a REC'D BY REGISTRAR <b>JUN 1 1966</b>		25b REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	





DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06681

CERTIFICATE OF DEATH

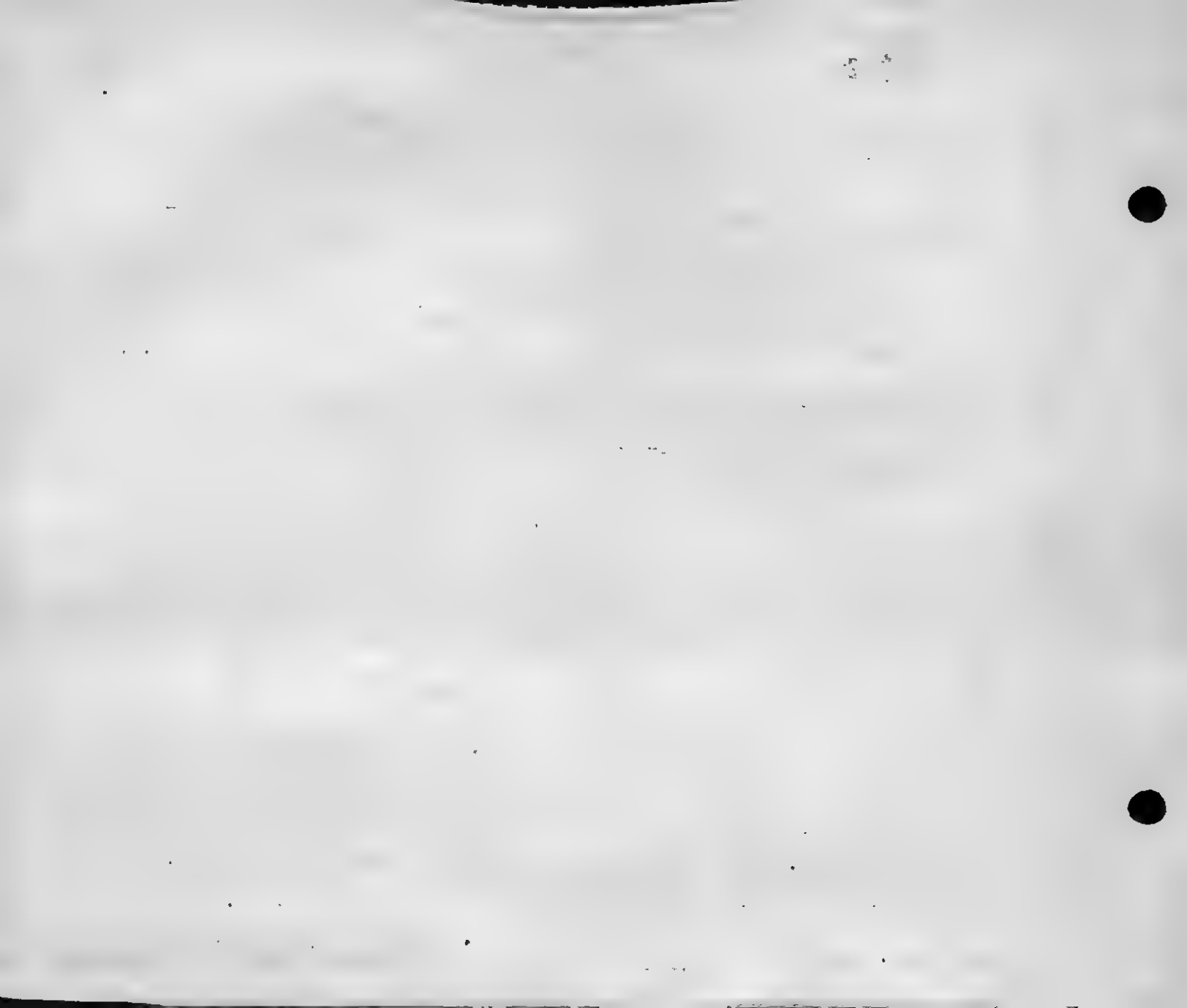
06674

Item 23b - film C371 2/25/66 mh

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>		d. STREET ADDRESS <u>1335 East Clement St. -30</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Timlin</u> Last <u>Timlin</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-1881</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>16</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Companion</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Anthony Timlin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Duffy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>X</u>		16. SOCIAL SECURITY NO. <u>212-32-1188</u>	
17. INFORMANT <u>Admission Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Crowd</u> Conditions, if any, which gave rise to immediate cause (b) <u>ASCD</u> (a), stating the underlying cause last, (c) <u>Serious</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 11</u> to <u>May 16</u> , 1966, that (I) (we) last saw the deceased alive on <u>5/16/66</u> at <u>1:55pm</u> , and that death occurred at <u>1:55pm</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Robert J. Mahon</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert Mahon</u>		22d. ADDRESS <u>204 East Joppa Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 20, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran, Inc.</u> ADDRESS <u>300 E. Baltimore</u>		25a. REC'D BY REGISTRAR <u>MAY 19 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

66682

66675

<b>1 PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND		<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD, MARYLAND</b>		c. LENGTH OF STAY IN 1b <b>23 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>SYLVAN SHORES</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>JEFFERSON M. TINGLE</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>MAY 6 1966</b>	
<b>5 SEX</b> <b>MALE</b>	<b>6 COLOR OR RACE</b> <b>WHITE</b>	<b>7 MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8 DATE OF BIRTH</b> <b>JAN. 2, 1895</b>
<b>9 AGE</b> (In years last birthday) yrs <b>71</b>		<b>10 UNDER 1 YEAR</b> Months Days Hours Min <b>71</b>	
<b>10a USUA. OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>ACCOUNTANT</b>		<b>10b KIND OF BUSINESS OR INDUSTRY</b> <b>U. S. GOVERNMENT</b>	
<b>11 BIRTHPLACE</b> (County & State, or foreign country) <b>ALABAMA</b>		<b>12 CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>JAMES M. TINGLE</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>CECELIA RUTLEDGE</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		<b>16. SOCIAL SECURITY NO.</b> <b>263 76 28 18</b>	
<b>17. INFORMANT</b> <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO (b) <b>CEREBROVASCULAR ARTERIOSCLEROSIS</b> DUE TO (c) <b>HYPERTENSIVE AND ARTERIOSCLEROTIC HEART DISEASE</b> <b>CYSTITIS, CHRONIC, CAUSATIVE ORGANISM UNKNOWN</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that</b> (this hospital) attended the deceased from <b>4/13/66</b> , 19__ to <b>5/6/66</b> , 19__, that (we) last saw the deceased alive on <b>5/6/66</b> , 19__, and that death occurred at <b>9:15 AM</b> , from causes and on the date stated above.	
<b>22a. SIGNATURE</b> <i>George Dudas</i> M.D.		<b>22b. DATE SIGNED</b> <b>5/6/66</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>GEORGE DUDAS, M. D.</b>		<b>22d. ADDRESS</b> <b>VAH FORT HOWARD, MARYLAND</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>5/11/1966</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ARLINGTON NATIONAL</b>		<b>23d. LOCATION (City or Town)</b> (County) (State) <b>ARLINGTON, VA.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>JOHN M. TAYLOR, SONS</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAY 10 1966</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>		<b>25c. ADDRESS</b> <b>DUKE OF GLOUCESTER ST. ANNAPOLIS, MD.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please prepare carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
C6683					C6676									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY							
Baltimore		MOUNT WILSON			Maryland		Prince george							
		c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
		1 year					Edgewater							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS									
Mount Wilson State Hospital					76 Dental Rd.									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
OWEN EUGENE TIPPETT					5 16 19 66									
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)						
M		W		NEVER MARRIED		2.9.1904		62						
				WIDOWED				IF UNDER 1 YEAR						
				DIVORCED				Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country)				
Farmer Tobacco					Own Farm					Mitchellville, Md.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					12. CITIZEN OF WHAT COUNTRY?				
JOSEPH TIPPETT					SARAH SMITH					USA				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address				
No										Records, Mt. Wilson State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										3 weeks				
352x DUE TO (b) Chronic cystitis										20 years				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Paraplegia										20 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES NO				
Far advanced pulmonary tuberculosis										YES NO				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED				
Hour a.m. p.m. 19										While at work Not While at work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 5.25, 1965, to 5.16, 1966 that (I) (we) last saw the deceased alive on 5.16, 1966, and that death occurred at 8:40, from the causes and on the date stated above.														
22a. SIGNATURE										22b. DATE SIGNED				
Wm. Newcomer										5.16.66.				
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS				
Wm. Newcomer, M.D., Superintendent										Mount Wilson State Hospital				
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF				
Burial										5/19/66				
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City, town or county) (State)				
Mt. Oak Cemetery										Mitchellville, Md.				
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				
Ritchie Bros. Upper Marlboro, Md.										MAY 18 1966 Charles Judge				

1977/10/10  
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06684

## CERTIFICATE OF DEATH

06677

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>2-14-1966</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u>	
c. LENGTH OF STAY IN lb <u>5 years</u>		d. STREET ADDRESS <u>7920 31st Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7920 31st Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>ANTHONY H. TRIBULL</u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 3, 1912</u>
9 AGE (In years - last birthday) yrs <u>54</u>		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman Tribull</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>213-01-0355</u>	
17 INFORMANT <u>John J. Tribull</u>		Address <u>7920 31st Street</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Metastatic Carcinoma, lung</u> DUE TO (c) <u>last</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>1966</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , 19 <u>66</u> , to <u>5/21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/21</u> , 19 <u>66</u> , and that death occurred at <u>2:30 A.M.</u> , from causes and on the date stated above			
22a SIGNATURE <u>John G. Orth, M.D.</u>		22b. DATE SIGNED	
22c PHYSICIAN'S (NAME) (Type)		22d ADDRESS <u>8014 Philadelphia Road.</u>	
23a BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>May 21, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24 FUNERAL DIRECTOR <u>Paul F. Gorch</u>		ADDRESS <u>1211 Sussex Avenue</u>	
25. REGD BY REGISTRAR DATE <u>MAY 24 1966</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

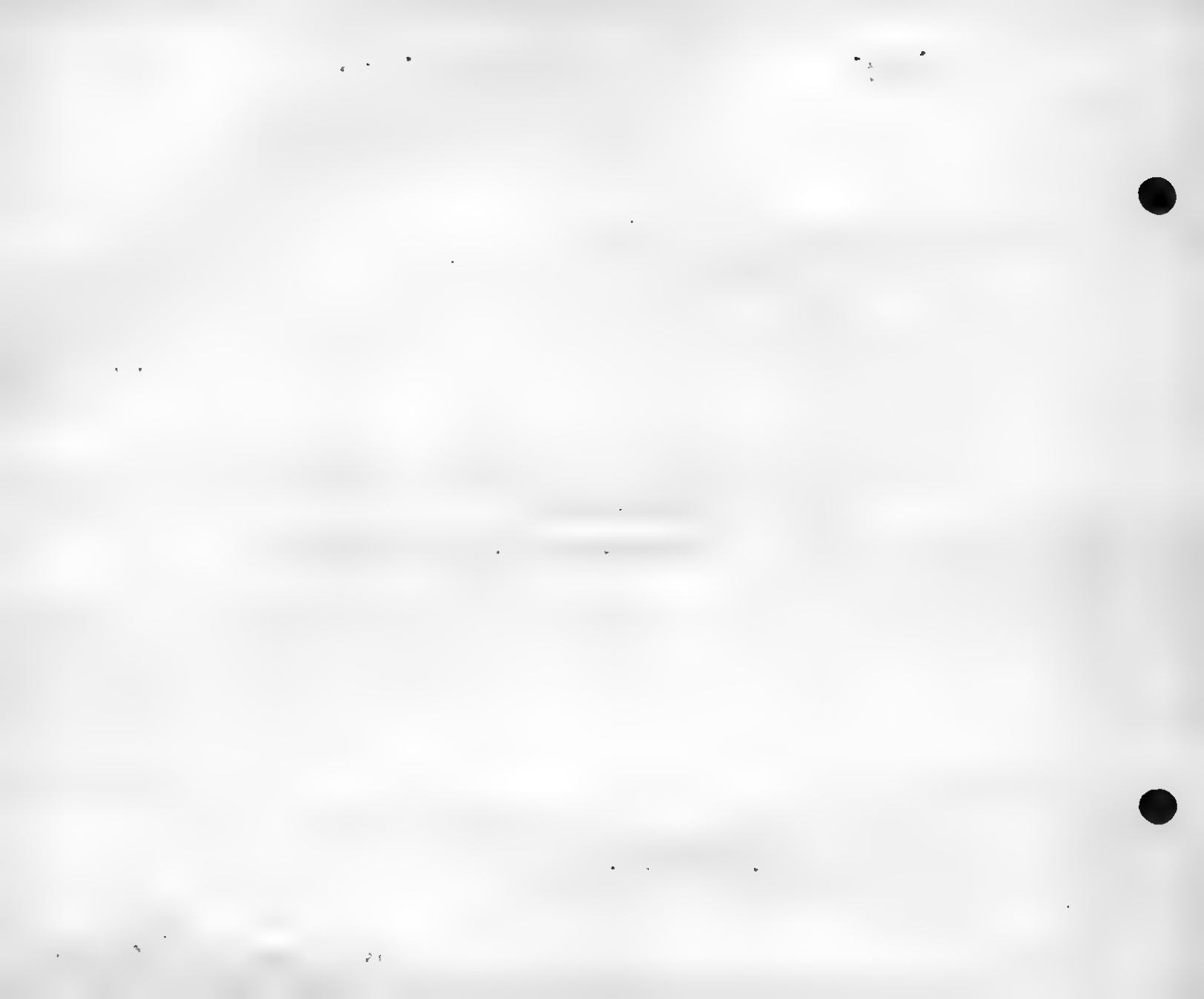
06685

06678

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>64 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>1620 West North Avenue</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>HOWARD LLOYD TUTMAN, SR</b>		4. DATE OF DEATH Month Day Year <b>MAY 8 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-27-1899</b>
9. AGE (In years last birthday) yrs <b>66</b>		10. IF UNDER 1 YEAR Months Days <b>66</b>	11. IF UNDER 24 HRS. Hours Min <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ROBERT TUTMAN</b>	
14. MOTHER'S MAIDEN NAME <b>IDA JOHNSON</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-1</b>	
16. SOCIAL SECURITY NO. <b>218 07 8618</b>		17. INFORMANT Address <b>CLIN REC VAH FT HOWARD MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO (b) <b>ENCEPHALOMYELITIS, CAUSE UNDETERMINED</b> DUE TO (c) <b>ENCEPHALOMYELITIS, CAUSE UNDETERMINED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 5, 19 66</b> , to <b>May 8, 19 66</b> that (I) (we) last saw the deceased alive on <b>May 8, 19 66</b> , and that death occurred at <b>10:10 a.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John D. Talbert</b>		22b. DATE SIGNED <b>5 9 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH, FT. HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-10-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>George Kelson</b> 1348 Calhoun St. Baltimore, Md.		25a. REC'D BY REGISTRAR <b>MAY 10 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>2 Hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>639 Sussex Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JANIE</b> Middle <b>LEE</b> Last <b>URCH</b>		4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1942</b>
9. AGE (In years last birthday) <b>23 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New Orleans, Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert G. Urch</b>		14. MOTHER'S MAIDEN NAME <b>Irene E. Hennegan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-40-9213</b>	
17. INFORMANT <b>Mr. Robert G. Urch, 639 Sussex Road, Towson 4, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing Injury of Skull</b> 8165 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause test. DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Driving auto that struck a bus head on</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>5:15</b> p.m. <b>5/4 19 66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		22. DATE SIGNED <b>5/4/66</b>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 7, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial</b>	23d. LOCATION (City, town or county) (State) <b>Cockeysville, Maryland</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road, Towson 4, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 9 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body. In any event, within 72 hours after death.

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20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1cm #9 Film 5/27/66 pc

CERTIFICATE OF DEATH

06687		06680	
1 PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore County - Randallstown</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. STREET ADDRESS <u>7014 Surey Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Johanna Ullweiler</u>		4. DATE OF DEATH Month <u>5</u> Day <u>25</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W -</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/1885</u> 9. AGE (In years last birthday) <u>79</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (County & State or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>MAX Oppenheimer</u>	
14. MOTHER'S MAIDEN NAME <u>BERTHA SCHLOSS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO. <u>220-48-1242</u>		17 INFORMANT Address <u>Mrs. S. Lewis 7014 Surey Drive</u>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>X</u> stating the underlying cause last. (c) <u></u> DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/27</u> , 19 <u>66</u> , to <u>5/25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/25</u> , 19 <u>66</u> , and that death occurred at <u>4:00 P.</u> M., from causes on and on the date stated above			
22a. SIGNATURE <u>R. Weinberger</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>R. Weinberger, M.D.</u>		22d. ADDRESS <u>3640 Fovels Lane - 21215</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>5/27/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CATHARINE ARNOLD CHESED</u>	23d. LOCATION (City or Town) (County) (State) <u>RANDALLSTOWN MD.</u>
24. FUNERAL DIRECTOR <u>JACK HENRY INC. 2100 2 ELITAW PL.</u>		25a. REC'D BY REGISTRAR <u>MAY 31 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06682

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>307 Butler Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>L. R.</b> Last <b>Walker</b>		4 DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Feb. 11, 1896</b>
9 AGE (in years) <b>70</b> (birth day) yrs		10 UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>James B. Walker</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Forsythe</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes W W 1</b>		16 SOCIAL SECURITY NO <b>212-01-2017</b>	
17 INFORMANT <b>Mrs. K. Estelle Walker</b>		Address <b>(Same)</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>+201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (a) <b>Coronary Thrombosis - acute</b> DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Clarence E. McWilliams, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Clarence E. McWilliams, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Charles J. Judge</b> Address (Street, city, town or county) <b>Reisterstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/6/66.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>	
24 FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>MAY 5 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space provided for the signature of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

CG689

CG688

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>606 Aldershot Rd.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>606 Aldershot Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Maurice</u> Middle <u>Leeson</u> Last <u>Walsh</u>				4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 13, 1892</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Draftsman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Metal</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Harry H. Walsh</u>				14. MOTHER'S MAIDEN NAME <u>Florence Leeson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <u>Mrs. Edna Walsh 606 Aldershot Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>0 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug.</u> , 19 <u>49</u> , to <u>May</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 25</u> , 19 <u>66</u> , and that death occurred at <u>OP</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Leo J. Gaver</u>				22b. DATE SIGNED <u>5/28/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver. M.D.</u>	
22d. ADDRESS <u>Mallow Hill Ave., Baltimore, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-31-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Foley-Cornwall H - Catonsville, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06690

06683

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>			c. LENGTH OF STAY IN 1b <b>9</b>	c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>				d. STREET ADDRESS <b>2909 DuPont Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Kenneth Louis WARREN</b> First <b>Louis</b> Middle Last				4. DATE OF DEATH <b>5</b> 19 <b>66</b> Month Day Year			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8 - 25 - 55</b>		9. AGE (In years last birthday) <b>10</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Warren</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Mason</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>Rosewood Records</b>		Address <b>Owings Mills, Md.</b>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: - IMMEDIATE CAUSE (a) <b>TRACHEOPNEUMONIA, ASPIRATION TYPE</b> <b>DOES</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ASPIRATION OF FOOD</b> DUE TO (c) <b>SEVERE DENTAL REGURGITATION</b>						INTERVAL BETWEEN ONSET AND DEATH <b>11 HOURS</b> <b>10 MINUTES</b> <b>16 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>MICROCEPHALY, CONGENITAL DISORDER, PARTIAL CLEFT PALATE</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/12, 1955</b> to <b>5/12, 1966</b> , that (I) (we) last saw the deceased alive on <b>5/12, 1966</b> , and that death occurred at <b>1:30 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>D. Percy Green</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>D. Percy Green</b>				22d. ADDRESS <b>1348 Calhoun St. Baltimore, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-4-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat'l Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>George H. Wilson</b> ADDRESS <b>1348 Calhoun St.</b>				25a. REC'D BY REGISTRAR <b>DATE MAY 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please take the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

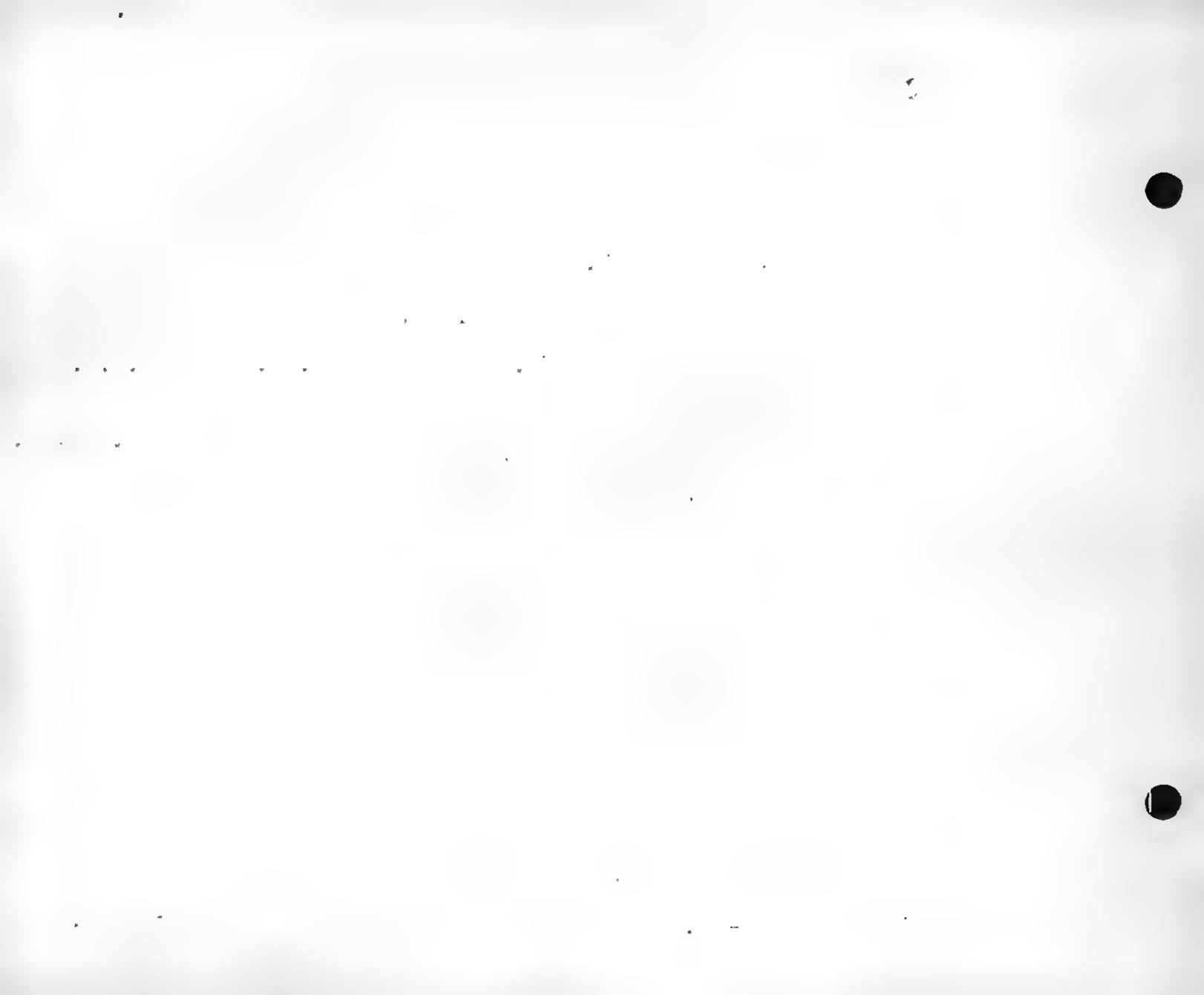
VR A15ME (5)  
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06691

06684

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>908 Thompson Bl'vd</b>				d. STREET ADDRESS <b>908 Thompson Boulevard</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>(ANNA) ANNA</b> First Middle Last <b>E. WAYLAND</b>				4. DATE OF DEATH Month Day Year <b>5 1 1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>Oct. 4, 1903</b>	
9. AGE (In years last birthday) yrs. <b>62</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Yellow Cab Co.</b>		11. BIRTHPLACE (State or foreign country) <b>W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stanley Green</b>				14. MOTHER'S MAIDEN NAME <b>M. Frances WALKER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>214-20-5627</b>		17. INFORMANT Address <b>Balto., 22, Md.</b> <b>Shirley Adey 4 North Point Terrace</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Shotgun wound of chest with multiple perforations of heart, left lung and aorta</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>X</b> (b) <b>XXXXX</b> (c) <b>DUE TO</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Shot by husband during altercation</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>9:15</b> <b>pm</b> <b>5-1-</b> <b>66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <b>Home</b>		20f. (City or town) (County) (State) <b>Essex Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>RUSSELL S. FISHER, M.D.</b>		CHIEF MED. CAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MED. CAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)					
22. DATE SIGNED <b>5-2-66</b>							
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-5-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>7225 Eastern Blvd. Ba. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Charles S. Zeiler</b>		ADDRESS <b>901 S. CONKLING ST. BALTO., 24, MD.</b>		25a. REC'D BY REGISTRAR <b>MAY 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

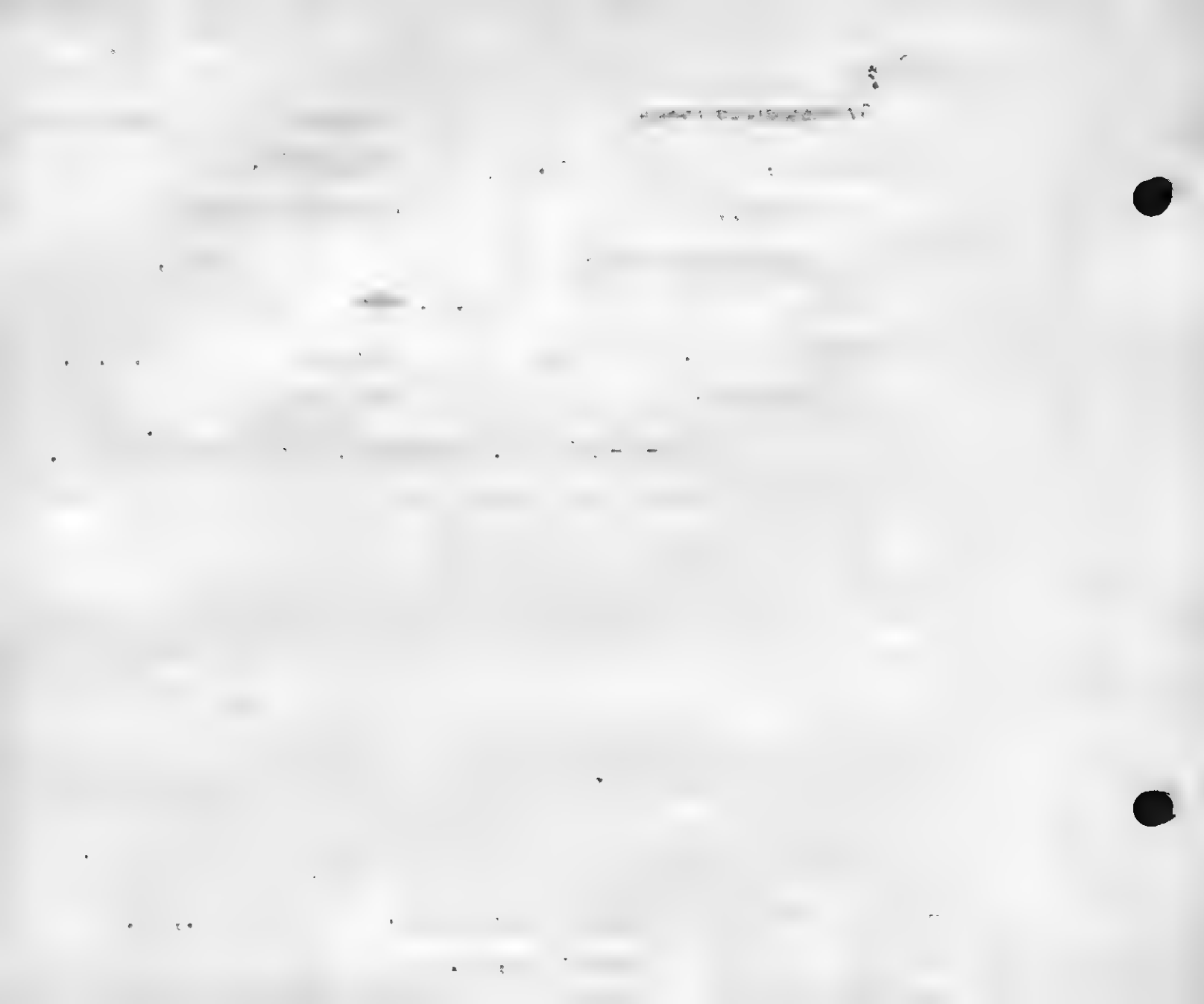


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville,</u>				c. LENGTH OF STAY IN 1b <u>55 yrs.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville,</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>37 Bloomsbury Avenue</u>				d. STREET ADDRESS <u>37 Bloomsbury Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henry Kennard Ways</u>				4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1966</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 8, 1901</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B. &amp; O. Railroad</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Bertram Ways</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Umbaugh</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>705-03-9511</u>		17. INFORMANT <u>Catonsville Md. 21228</u> <u>Mrs. Elizabeth E. Ways 37 Bloomsbury Ave.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 1201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO										INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 11, 1948</u> , to <u>May 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 9, 1966</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Wilmer K. Gallagher, Sr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>5-10-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, Sr.</u>				22d. ADDRESS <u>6209 Frederick Ave. Bldg. 28 Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/12/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mountain View Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Howard Co., Md.</u>			
24. FUNERAL DIRECTOR <u>Easton Funeral Home</u>				ADDRESS <u>Catonsville, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





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1 (M)

C6693

CERTIFICATE OF DEATH

C6686

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> c. LENGTH OF STAY IN 1b <b>30</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>2901 PUGET STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHANNA E. WEIDE</b>		4. DATE OF DEATH Month Day Year <b>MAY 20, 19 66</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-24-88</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. FUND 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ERNEST DOMSCHKE</b>		14. MOTHER'S MAIDEN NAME <b>WILAMENA HARTUNG</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. GEORGE R. WEIDE, 2901 PUGET ST.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/12/66</b> , to <b>MAY 20, 19 66</b> , that (I) (we) last saw the deceased alive on <b>MAY 20 19 66</b> , and that death occurred at <b>4</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Barry N. Rosenbaum</b>		22b. DATE SIGNED <b>5/23/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>BARRY N. ROSENBAUM</b>		22d. ADDRESS <b>UNIVERSITY HOSPITAL</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5-24-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD, 4107 WILKENS AVE.</b>		25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

66694

66687

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>26 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>W.</b> Last <b>WELLING</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>4</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/6/26</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RADIO DISPATCHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DAIRY</b>	
11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NEVIN L. WELLING</b>		14. MOTHER'S MAIDEN NAME <b>LILLY M. MN: MALONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>218 18 796</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>163X CARCINOMA OF THE LUNG WITH METASTASIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/8/66</b> , 19__, to <b>5/4/66</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>5/4/66</b> , 19__, and that death occurred at <b>12:20 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Raul F. de Castro</i>		22b. DATE SIGNED <b>5/4/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>RAUL F. DE CASTRO, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>May 9 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>JOHN J. DUDA,</b>		25a. REC'D BY REGISTRAR <b>JOHN J. DUDA FUNERAL HOME</b> DATE <b>5 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

WISE AVE. BALTIMORE, MD.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06695

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06689

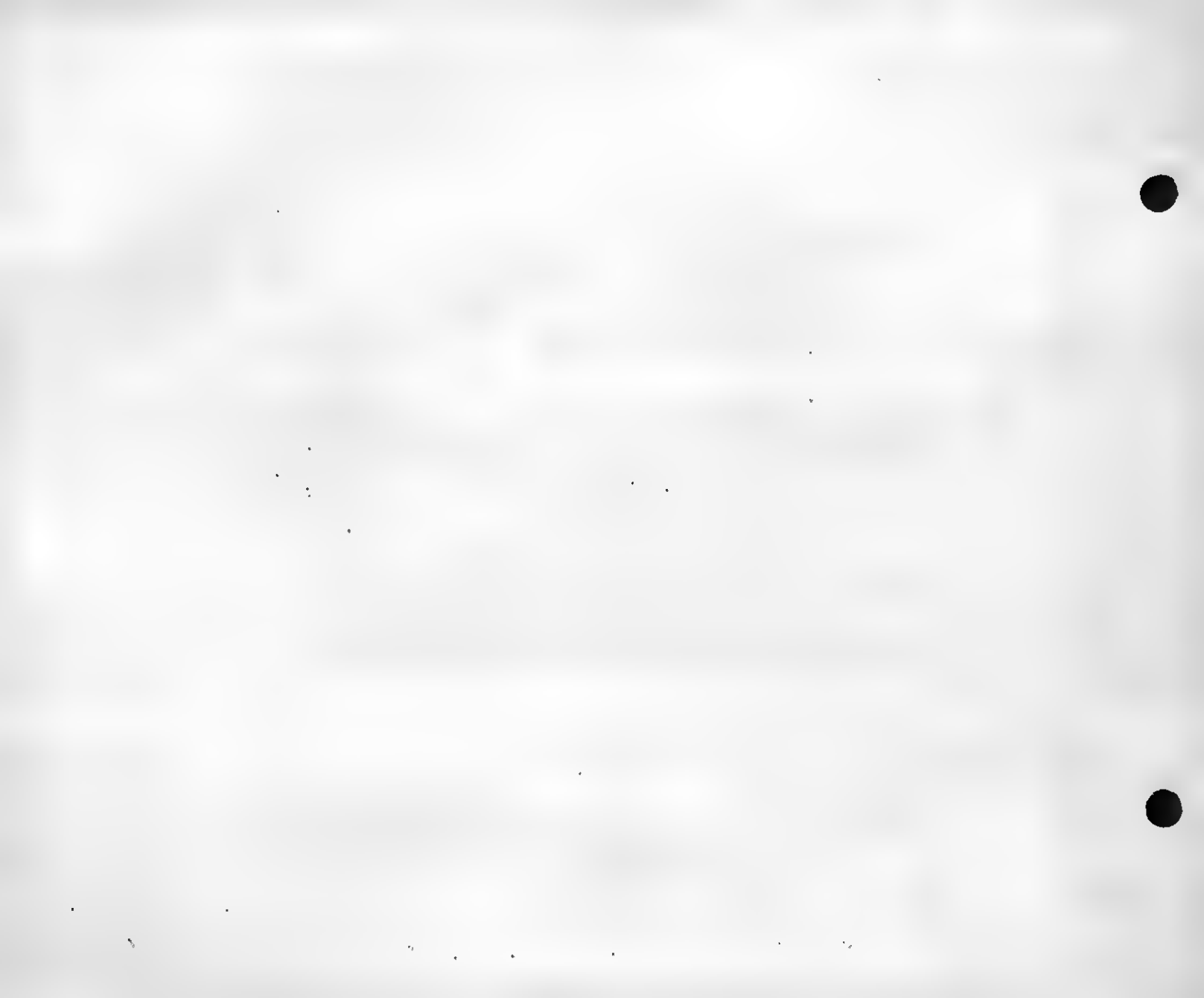
1 PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>		c. LENGTH OF STAY IN 1b <b>Baltimore 12</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2 Knollridge Court - Apt. 1631</b>		d. STREET ADDRESS <b>2 Knollridge Court 1631</b>	
3 NAME OF DECEASED (Type or print) <b>Adele Trebus Wennerstrom</b>		4 DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1966</b>	
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>9/3/1896</b>
9 AGE (in years last birthday) <b>69</b> yrs		10 FUND 1 YEAR Months <b>10</b> Days <b>19</b> Hours <b>66</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11 BIRTHPLACE (State or foreign country) <b>St. Louis, Mo.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert C. Trebus</b>		14. MOTHER'S MAIDEN NAME <b>Ida Schulze</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>090-07-8236B</b>	
17 INFORMANT <b>Albert E. Wennerstrom</b>		Address <b>(Same)</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4222</b> DUE TO (b) <b>Chronic Myocardial Failure</b> DUE TO (c) <b>Sudden</b> INTERVAL BETWEEN ONSET AND DEATH <b>Several years</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF DEATH Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Dr. Charles F. O'Donnell</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>5/10/66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Removal</b>		23b. DATE THEREOF <b>5/13/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran</b>		23d. LOCATION (City or Town) (County) (State) <b>Metropolitan Ave. Queens, N.Y.</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 11 1966</b>	
ADDRESS <b>1905 York Rd. Balto. 12, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05696						06690					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randalltown Md.</u>				c. LENGTH OF STAY IN ID		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Balto. Co. General Hosp.</u>						d. STREET ADDRESS <u>4500 Dunland Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Herman</u>			First Middle Last			4. DATE OF DEATH <u>West</u>			Month Day Year <u>5 6 19 66</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 16, 1891</u>		9. AGE (in years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secy &amp; Treas. Schafer Co Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Maryland</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Oswald T. West</u>						14. MOTHER'S MAIDEN NAME <u>Wilhelmina Schafer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes World War # 1</u>				16. SOCIAL SECURITY NO. <u>215 09 1889</u>		17. INFORMANT <u>Mrs Charlotte J. West</u> Address <u>4501 Dunland Road 21229</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Acute Anterior Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Blushing Pectoral Artery</u> DUE TO (c) <u>Blushing Pectoral Artery</u>						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> , 19 <u>66</u> , to <u>5/6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/6</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Henry Sander &amp; Sons</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>5/6/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Henry Sander &amp; Sons Inc. Balto. MD.</u>						22d. ADDRESS <u>Baltimore County General Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/10/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>					
24. FUNERAL DIRECTOR <u>Henry Sander &amp; Sons Inc. Balto. MD.</u>						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
DATE <u>MAY 10 1966</u>											





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06697

## CERTIFICATE OF DEATH

06691

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Baltimore</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> <span style="float: right;">b. COUNTY <span style="font-size: 1.2em;">Baltimore</span></span>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <span style="font-size: 1.2em;">Baltimore 12</span>			c. LENGTH OF STAY IN 1b  		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Baltimore</span> <span style="float: right;">03-1</span>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <span style="font-size: 1.2em;">Woodbrook Lane</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">Woodbrook Lane</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">Robert H. Wheeler</span>				<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">May</span> Day <span style="font-size: 1.2em;">18</span> Year <span style="font-size: 1.2em;">1966</span>			
5. SEX <span style="font-size: 1.2em;">M</span>		6. COLOR OR RACE <span style="font-size: 1.2em;">W</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">9/8/1894</span>	
9. AGE (n years last birthday) yrs <span style="font-size: 1.2em;">71</span>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Executive</span>		10b. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Insurance</span>		11. BIRTHPLACE (County & State, or foreign country) <span style="font-size: 1.2em;">Balto. Co., Towson, Md.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>				13. FATHER'S NAME <span style="font-size: 1.2em;">Frank I. Wheeler</span>			
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Annie F. German</span>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <span style="font-size: 1.2em;">Yes WWI</span>			
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">218-32-4006</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Ruby L. Wheeler</span>		Address <span style="font-size: 1.2em;">(same)</span>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Pneumonia of unknown origin</span> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <span style="font-size: 1.2em;">180x</span> DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <span style="font-size: 1.2em;">19</span> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">6/16/61</span> , 19 <span style="font-size: 1.2em;">61</span> , to <span style="font-size: 1.2em;">5-18</span> , 19 <span style="font-size: 1.2em;">66</span> ; that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5-17</span> , 19 <span style="font-size: 1.2em;">66</span> , and that death occurred at <span style="font-size: 1.2em;">6A</span> M, from causes and on the date stated above.							
22a. SIGNATURE <span style="font-size: 1.2em;">Franklin E. Leslie</span>				22b. DATE SIGNED  		22c. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. Franklin E. Leslie</span>	
22d. ADDRESS <span style="font-size: 1.2em;">302 E. 33rd St.</span>		23a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>					
23b. DATE THEREOF <span style="font-size: 1.2em;">5/21/1966</span>		23c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Prospect Hill</span>		23d. LOCATION (City or Town) (County) (State) <span style="font-size: 1.2em;">Towson, Balto. Co., Md.</span>		24. FUNERAL DIRECTOR <span style="font-size: 1.2em;">H.W. Jenkins &amp; Sons Co.</span>	
25a. REC'D BY REGISTRAR <span style="font-size: 1.2em;">MAY 23 1966</span>		25b. REGISTRAR'S SIGNATURE <span style="font-size: 1.2em;">Charles Judge</span>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06693

06692

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>44 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DONALD VIVIAN WHITE, SR.</b>		4. DATE OF DEATH Month Day Year <b>MAY 20, 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 6, 1914</b>
9. AGE (In years last birthday) yrs <b>52</b>		10. UNDER 1 YEAR Months Days 11. UNDER 24 Hrs Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GOOD HUMOR ICE / CREAM</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>RICHARD H. WHITE</b>		14. MOTHER'S MAIDEN NAME <b>NELLIE MAE MATHIAS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO <b>215 10 56 29</b>	
17. INFORMANT <b>VA HOSPITAL</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO (b) <b>ARTERIO SCLEROTIC HEARTDISEASE</b> DUE TO (c) <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>1</b> (this hospital) attended the deceased from <b>APRIL 6,</b> 19 <b>66</b> , to <b>MAY 20 2/19 66</b> that <b>1</b> (we) lost saw the deceased alive on <b>MAY 20</b> 19 <b>66</b> , and that death occurred at <b>1125AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>WON JU HAHN, M.D.</b>		22b. DATE SIGNED <b>5/21/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>WON JU HAHN, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/24/66.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>L. J. RUCK, INC.</b>		25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

VR A15 (4)  
20 M 1/66



## CERTIFICATE OF DEATH

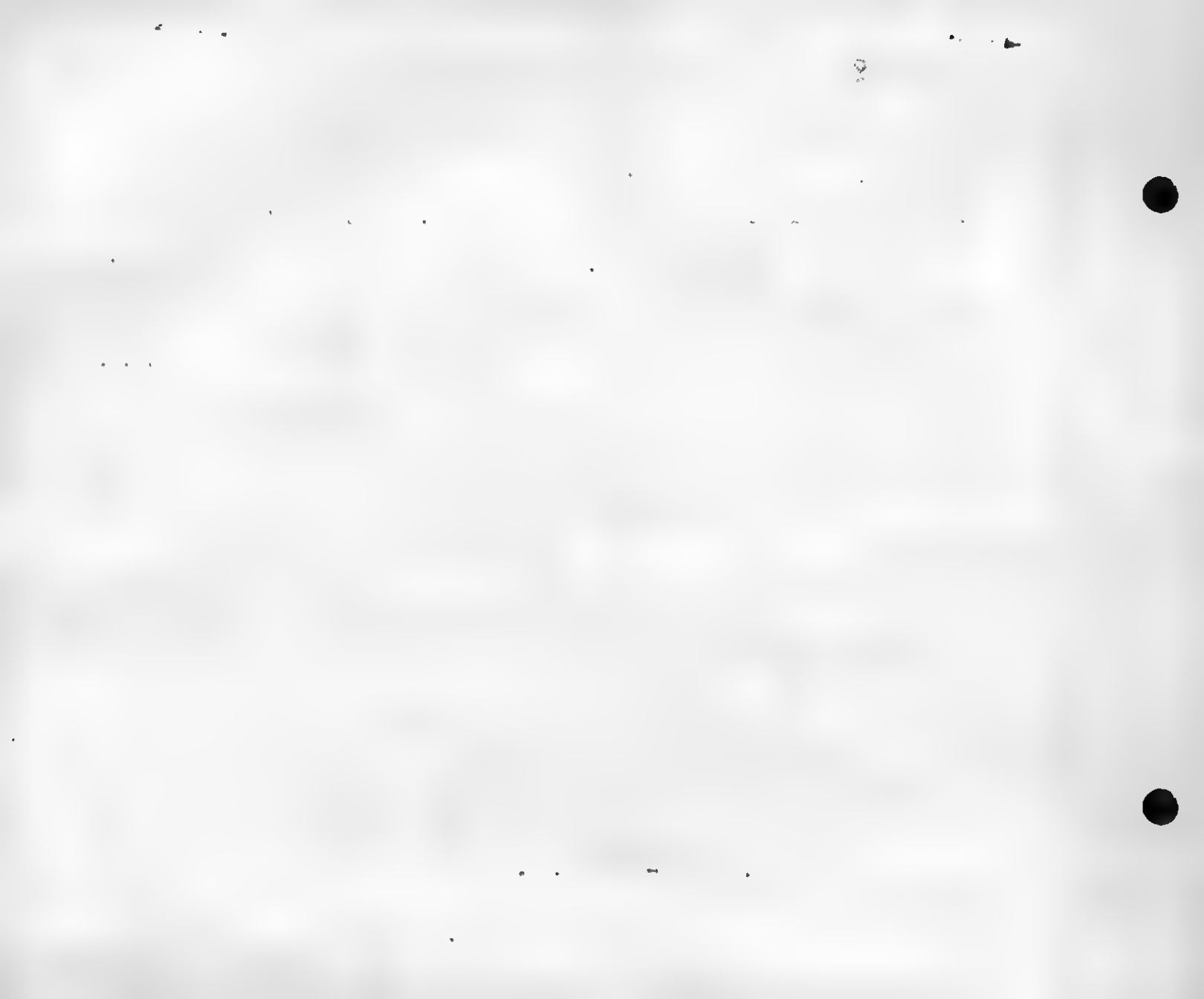
06699

06693

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 15 <b>8 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>426 E. Pratt Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM S. WHITE</b>		4 DATE OF DEATH Month Day Year <b>MAY 20 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>11/23/12</b>
9 AGE (In years last birthday) yrs <b>53</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>LURAY, VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ELMER P. WHITE</b>	
14. MOTHER'S MAIDEN NAME <b>VINNIE STRICKLER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-11</b>	
16. SOCIAL SECURITY NO. <b>214 12 26 18</b>		17. INFORMANT <b>Clinical Records, VAH, Fort Howard, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>SEVERE MALNUTRITION</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 12</b> , 19 <b>66</b> , to <b>May 20</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 20</b> , 19 <b>66</b> , and that death occurred at <b>a.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Alicia O. Mendez-Ross</i>		22b. DATE SIGNED <b>5 21 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALICIA O. MENDEZ-ROSS, M. D.</b>		22d. ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5/24/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOUIS PARK NATIONAL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>		25a. BY REGISTRAR <b>JUN 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06700

06694

1. PLACE OF DEATH  
a. COUNTY **Baltimore** MARYLAND  
b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) **Essex (21)**  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  
**265 Southeastern Terrace**

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE **Maryland** b. COUNTY **Baltimore**  
c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)  
**Essex (21)**

3. NAME OF DECEASED (Type or print)  
First Middle Last  
**Sidney Williams**

4. DATE OF DEATH  
Month Day Year  
**May 16, 1966**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH  
**Aug. 16, 1894**

9. AGE (In years (If UNDER 1 YEAR IF UNDER 24 HRS. (or birthday) Months Days Hours Min.  
**71** yrs. **71** Months **71** Days **71** Hours **71** Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Mechanic**  
10b. KIND OF BUSINESS OR INDUSTRY **Aircraft Co.**  
11. BIRTHPLACE (State or foreign country) **Maryland**  
12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Stonewall J. Williams**  
14. MOTHER'S MAIDEN NAME **Sarah Curran**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **217 22 0671** 17. INFORMANT **Sidney J. Williams, Jr.** Address **Same**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) **Acute Cerebral Vascular Accident**  
DUE TO (b) **Hypertensive Cardiovascular Disease**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  
20c. TIME OF INJURY Month Day Year **6:30 a.m. 5/16/66** 20d. INJURY OCCURRED While at work ☐ Not While at work ☒  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ inspection ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE **Theodore C. Patterson**  
EXAMINER'S NAME (Type) **Theodore C. Patterson, M.D. 105 Main St. Dundalk, Md. 21222**  
DATE SIGNED **5/16/66**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **5/19/66** 22c. NAME OF CEMETERY OR CREMATORY **Gardens of Faith Cemetery** 22d. LOCATION (City, town or country) **Baltimore Co., Md.**

23. FUNERAL DIRECTOR ADDRESS **Bruzdzinski Funeral Home 1407 Eastern Ave. #21**  
24a. REC'D BY REGISTRAR **MAY 18 1966** 24b. REGISTRAR'S SIGNATURE **Charles Judge**

MEDICAL CERTIFICATION





06701

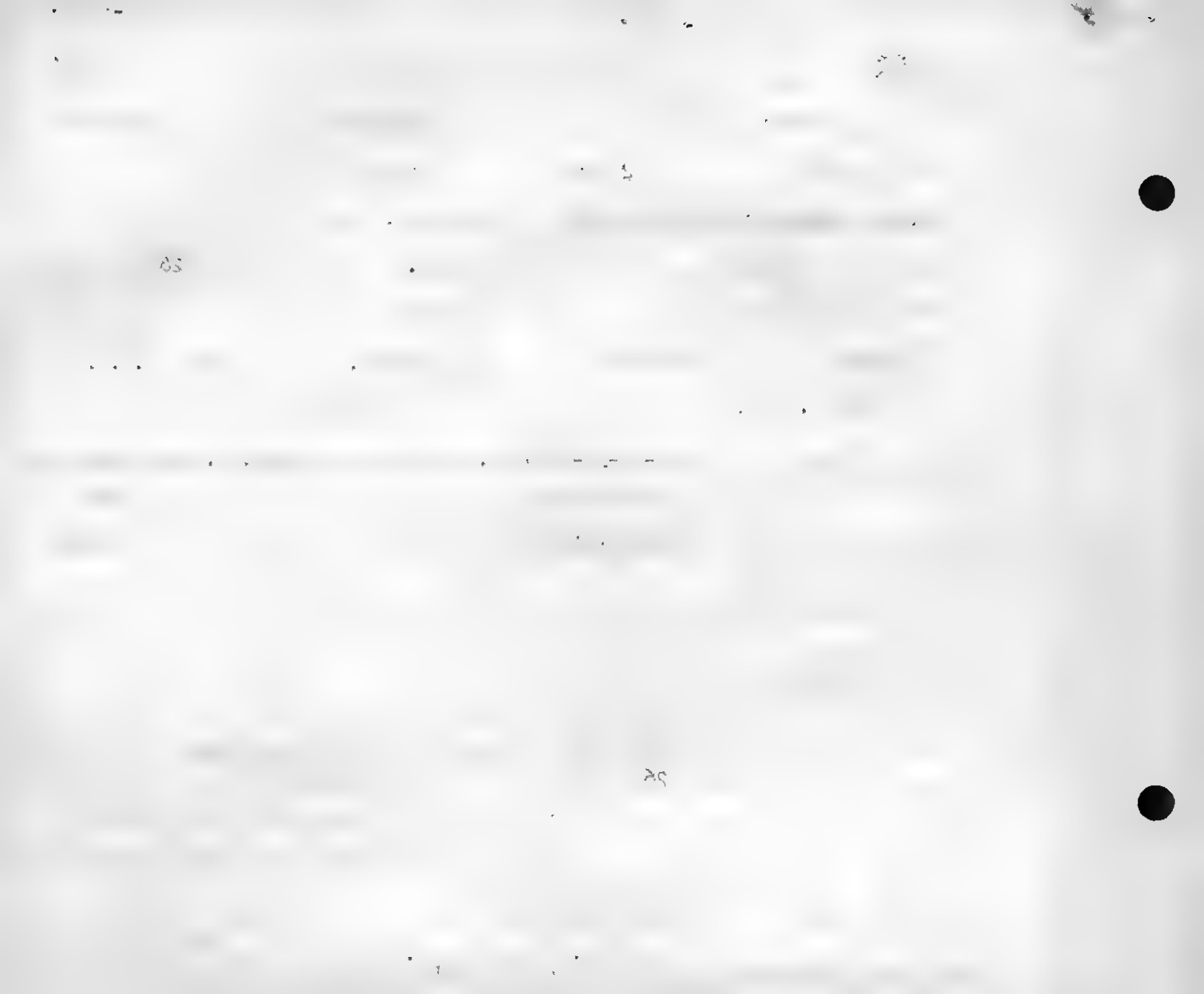
## CERTIFICATE OF DEATH

06695

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>2 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Box 181, Route 3</b>	
3 NAME OF DECEASED (Type or print) <b>AARON (NMI) WILSON SR.</b>		4. DATE OF DEATH <b>MAY 26TH 1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/19/12</b>
9 AGE (In years last birthday) <b>53</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Heathsprng, South Carolina U.S.A.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Allen O. Hall</b>		14. MOTHER'S MAIDEN NAME <b>Ida Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>219-01-37-68</b>	
17. INFORMANT <b>Clin. Records, VA Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <b>CANCER OF LUNG</b>			
DUE TO (b) <b>BRONCHOGENIC CA</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>May 24</b> , 19 <b>66</b> , to <b>May 26</b> , 1966, that (1) (we) last saw the deceased alive on <b>May 26</b> , 19 <b>66</b> , and that death occurred at <b>11:30PM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Charles E. Judge</i> M.D.		22b. DATE SIGNED <b>5/28/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/31/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		25. REC'D BY REGISTRAR <b>31 MAY 1966</b>	
25a. REGISTRAR'S SIGNATURE <i>Charles E. Judge</i>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

66702

66696

1. PLACE OF DEATH a. COUNTY <i>Balto Co</i> <i>Catonsville</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> d. STREET ADDRESS <i>2325 Eastern Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>House in Pines</i>		4. DATE OF DEATH Month <i>MAY</i> Day <i>26</i> Year <i>1966</i>		3. NAME OF DECEASED (Type or print) <i>DAVID E WILSON</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-31-1894</i>	9. AGE (In years last birthday) <i>72 yrs.</i>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Md. Dry Dock</i>		11. BIRTHPLACE (County & State, or foreign country) <i>PA.</i>	
13. FATHER'S NAME <i>DANIEL Z. Wilson</i>		12. CITIZEN OF WHAT COUNTRY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of service) <i>YES W.W.I.</i>		16. SOCIAL SECURITY NO. <i>522-09-7578A</i>		17. INFORMANT <i>Mrs. Ramsey</i> Address <i>2325 Eastern Ave.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO (b) <i>arteriosclerotic cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Emphysema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>10 yr.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-23</i> <i>1965</i> to <i>5-31</i> <i>1966</i> , that (I) (we) last saw the deceased alive on <i>5-25</i> <i>1966</i> , and that death occurred at <i>1230 A.M.</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>Wilmer K. Ballager Sr.</i> M.D.		22b. DATE SIGNED <i>5-26-66</i>		22c. PHYSICIAN'S NAME (Type) <i>Wilmer K. Ballager Sr.</i>	
22d. ADDRESS <i>6209 Frederick Ave. Balt. 21228 Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>5-28-1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Balto. National</i>	
23d. LOCATION (City, town or county) <i>Md.</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Hoffmann Funeral Home</i>		ADDRESS <i>3218 Hudson</i>		25a. REC'D BY REGISTRAR <i>MAY 27 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MEDICAL CERTIFICATION



06703

## CERTIFICATE OF DEATH

06697

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2mth2dys</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>521 Yale Avenue</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna E. Winemiller</b>		4. DATE OF DEATH Month Day Year <b>May 23 19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1883</b>
9. AGE (In years) <b>82</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Matthew William McCauley</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Mixer</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>	
16. SOCIAL SECURITY NO <b>unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARDIAC + RESPIRATORY ARREST</b> 4330 DUE TO (b) <b>PNEUMONIA</b> DUE TO (c) <b>GASTROINTESTINAL BLEEDING</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIO-SCLEROSIS CARDIOVASCULAR DISEASE</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if this hospital) attended the deceased from <b>March 19, 19 66</b> to <b>May 23, 19 66</b> , that (if) (we) last saw the deceased alive on <b>May 23, 19 66</b> , and that death occurred at <b>6:55</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>Wachsler</b> M.D.		22b. DATE SIGNED <b>5-24-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 26, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>
24. FUNERAL DIRECTOR ADDRESS <b>G. Truman Schwab 3512 Frederick Ave. Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 26 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>						c. LENGTH OF STAY IN 1b <b>3 Mo's &amp; 20 days</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Forest Haven Nursing Home</b>						e. STREET ADDRESS <b>1026 Riverside Avenue</b>					
3. NAME OF DECEASED (Type or print) First <b>Christine</b> Middle <b>Winkler</b> Last						4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 22, 1875</b>		9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>?</b>						14. MOTHER'S MAIDEN NAME <b>?</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Mrs. Edith Cucina</b> Address <b>1421 S. Hanover St.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic cardiac - vascular</b> DUE TO (c) <b>dissecting</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1/1</b> , 19 <b>66</b> , to <b>5/24</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/24</b> , 19 <b>66</b> , and that death occurred at <b>6:30 a.m.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>John F. Denny</b>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>John F. Denny M.D.</b>						22d. ADDRESS <b>5500 Edmonson Ave. Apt. 1</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>				
24. FUNERAL DIRECTOR <b>JOHN F. DENNY, INC. 715 Light St.</b>						25a. REC'D BY REGISTRAR <b>MAY 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06705 <span style="float: right;">06699</span>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4106 Asbury Avenue</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton (Rural)</u> d. STREET ADDRESS <u>4106 Asbury Avenue #36</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>J.</u> Last <u>Mirsing</u>			4. DATE OF DEATH Month <u>5</u> Day <u>29</u> Year <u>1966</u>		5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Co. Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Ausbury Whenowith</u>					14. MOTHER'S MAIDEN NAME <u>Dora Meise</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>229-20-0150</u>		17. INFORMANT <u>Mr Walter Mirsing 4106 Asbury Avenue</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>443X</u> DUE TO (b) <u>arteriosclerosis, ACVD, hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>diabetes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>5-29</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>March 1965</u> to <u>5-29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-29</u> , 19 <u>66</u> , and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Dr. R. Rigler</u>					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>DR. RICHARD R. RIGLER</u>				
22d. ADDRESS <u>1 W. OVERLEA AVE. CITY 6</u>					22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>6-1-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air. Md.</u>				
24. FUNERAL DIRECTOR <u>Lassahn Turner Home 7401 Bel Air Road</u>					25a. REC'D BY REGISTRAR <u>JUN 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



CERTIFICATE OF DEATH

06706

06700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>140 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>3529 OAKMONT AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>H.</b> Last <b>WISE</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>12</b> Year <b>1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 8, 1917</b>	
9. AGE (In years last birthday) <b>48</b> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if ret red) <b>REFRIGERATION MAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. C.T. ZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>LEON S. WISE</b>				14. MOTHER'S MAIDEN NAME <b>ANNA R. ROCKWELL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO <b>214 12 0111</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG, LEFT WITH METASTASES TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CEREBELLUM, KIDNEYS AND ADRENALS</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1634</b> YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/22/65</b> , 19__, to <b>5/12/66</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>5/12/66</b> , 19__, and that death occurred at <b>7:20AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>J. D. Talbert</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/12/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/16/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Wm. F. Tickner &amp; Sons</b>				25a. REC'D BY REGISTRAR <b>MAY 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

MEDICAL CERTIFICATION

<div> <div>1</div> <div>8</div> </div> <div> <div>66707</div> <div>66701</div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>506 F. STREET</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u> d. STREET ADDRESS <u>506 F. STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>THOMAS R. WOOD</u> <b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>MILLWRIGHT</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>STEEL</u>						<b>4. DATE OF DEATH</b> Month <u>MAY</u> Day <u>9</u> Year <u>1966</u> <b>8. DATE OF BIRTH</b> <u>JAN 31, 1907</u> <b>9. AGE</b> (In years last birthday) <u>59</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>PENNA</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>					
<b>13. FATHER'S NAME</b> <u>THOMAS A WOOD</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>BERTHA DEITER</u>						<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>213-07-9984</u> <b>17. INFORMANT</b> <u>BERTHA A WOOD</u> Address <u>506 F ST</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>4201</u> DUE TO <u>ACHD</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> (b) <u>  </u> (c) <u>  </u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>5/9/66</u> Hour <u>8</u> p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u> <b>20f. (City or town)</b> <u>SPR PT MD</u> <b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>ACTUAL SIGNATURE</b> <u>Theo C. Patterson</u> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>THEO C. PATTERSON</u> <b>M.O. ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>22. DATE SIGNED</b> <u>5/10/66</u> <b>Address (Street, city, town, or county)</b> <u>  </u>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>5/13/66</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>BEAR MEMORIAL</u> <b>23d. LOCATION (City, town or county)</b> <u>BEAIR</u> <b>(State)</b> <u>MD</u>				<b>24. FUNERAL DIRECTOR</b> <u>ULLRICH FUNERAL HOME - DUNDALK MD</u> <b>ADDRESS</b> <u>  </u> <b>25a. REC'D BY REGISTRAR</b> <u>MAY 12 1966</u> <b>DATE</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Johnas Judge</u>							



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06702

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Besse</u> c. LENGTH OF STAY IN b. <u>6</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp (al), give street address) <u>331 Forner Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Besse</u> d. STREET ADDRESS <u>331 Forner Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THORNTON M WOODARD</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. CO. OR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/30/24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Martins</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. 8. RTH. PLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thornton Woodard</u>		14. MOTHER'S MAIDEN NAME <u>Eliz. Rupp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Wife (same as above.)</u>	
17. INFORMANT <u>Wife (same as above.)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>coronary artery disease</u> (b) DUE TO <u>coronary artery disease</u> (c) DUE TO <u>coronary artery disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year <u>6/30 p.m. 5/17/66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>car accident</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) <u>car accident</u>		20f. (City or town) (County) (State) <u>Essex Balto. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>5/18/66</u>	
ACTUAL SIGNATURE <u>Theo C. Patterson</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>THEOC. PATTERSON</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>5/20/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>
24. FUNERAL DIRECTOR <u>Connelly Sons 300 Mace Ave. (21)</u>		25a. REC'D BY REGISTRAR <u>MAY 20 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.





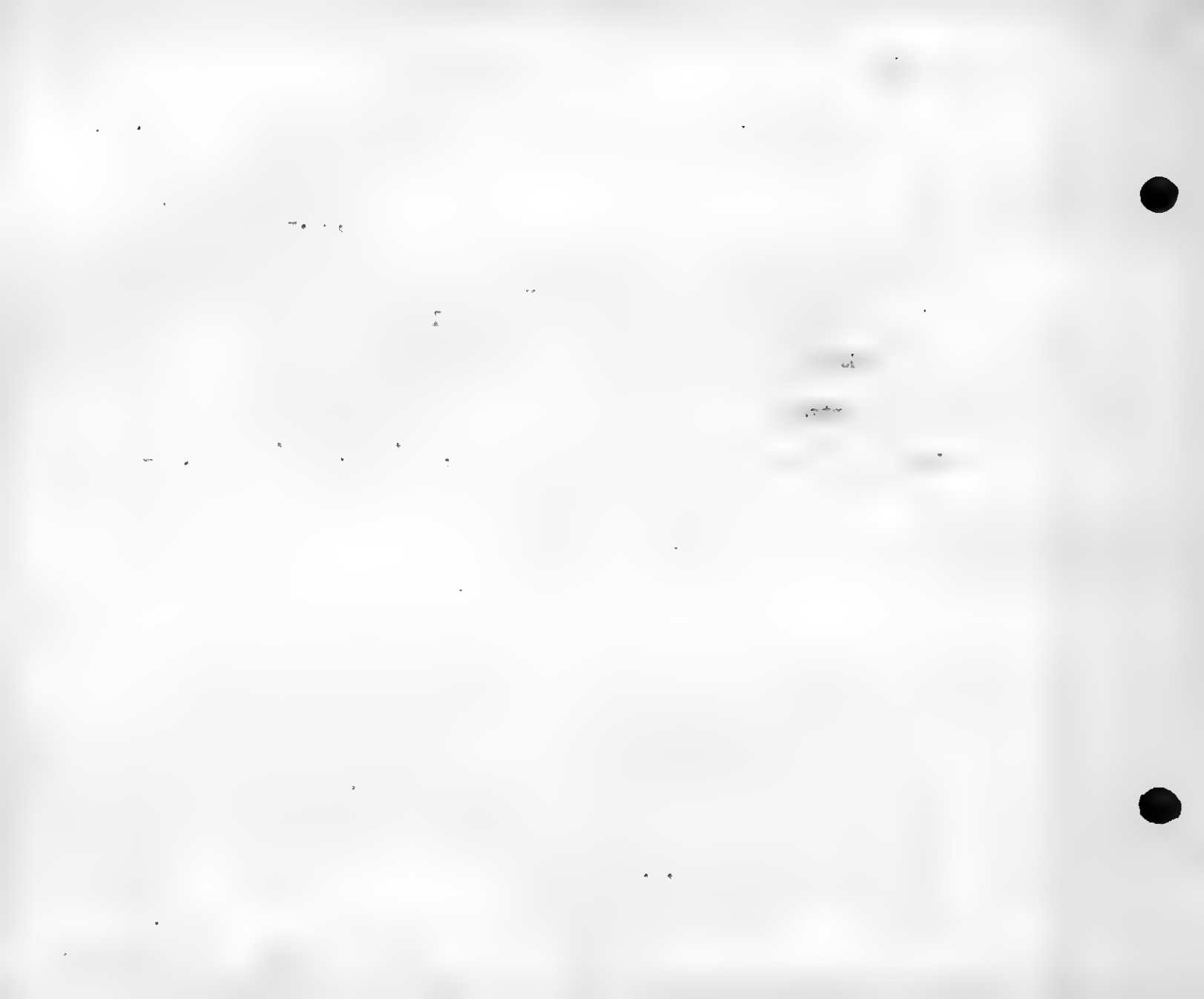
## CERTIFICATE OF DEATH

C6703

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>2mth18dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		e. STREET ADDRESS <b>315 Shady Nook Ave. Catonsville, Md.-21228</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Edward Wurtzer</b>		4. DATE OF DEATH Month Day Year <b>May 22 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1901</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas Company</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Anthony Wertzer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ellen Kilroy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <b>None None</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mrs. Joseph L. Locke</b> Address <b>sister: 3723 Manchester Avenue -Baltimore, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>(possible) Coronary Occlusion</b> DUE TO (c) <b>Hypertensive Arteriosclerotic Cardio-Vascular Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>March 4, 1966</b> , to <b>May 22, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 22, 1966</b> , and that death occurred at <b>8:32 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Imre Kopits</i>		22b. DATE SIGNED <b>5-22-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Imre Kopits, M.D.</b>		22d. ADDRESS <b>Spring Grove State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/25/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>M. J. Suber</b>		25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. Under any event, within 72 hours after death.

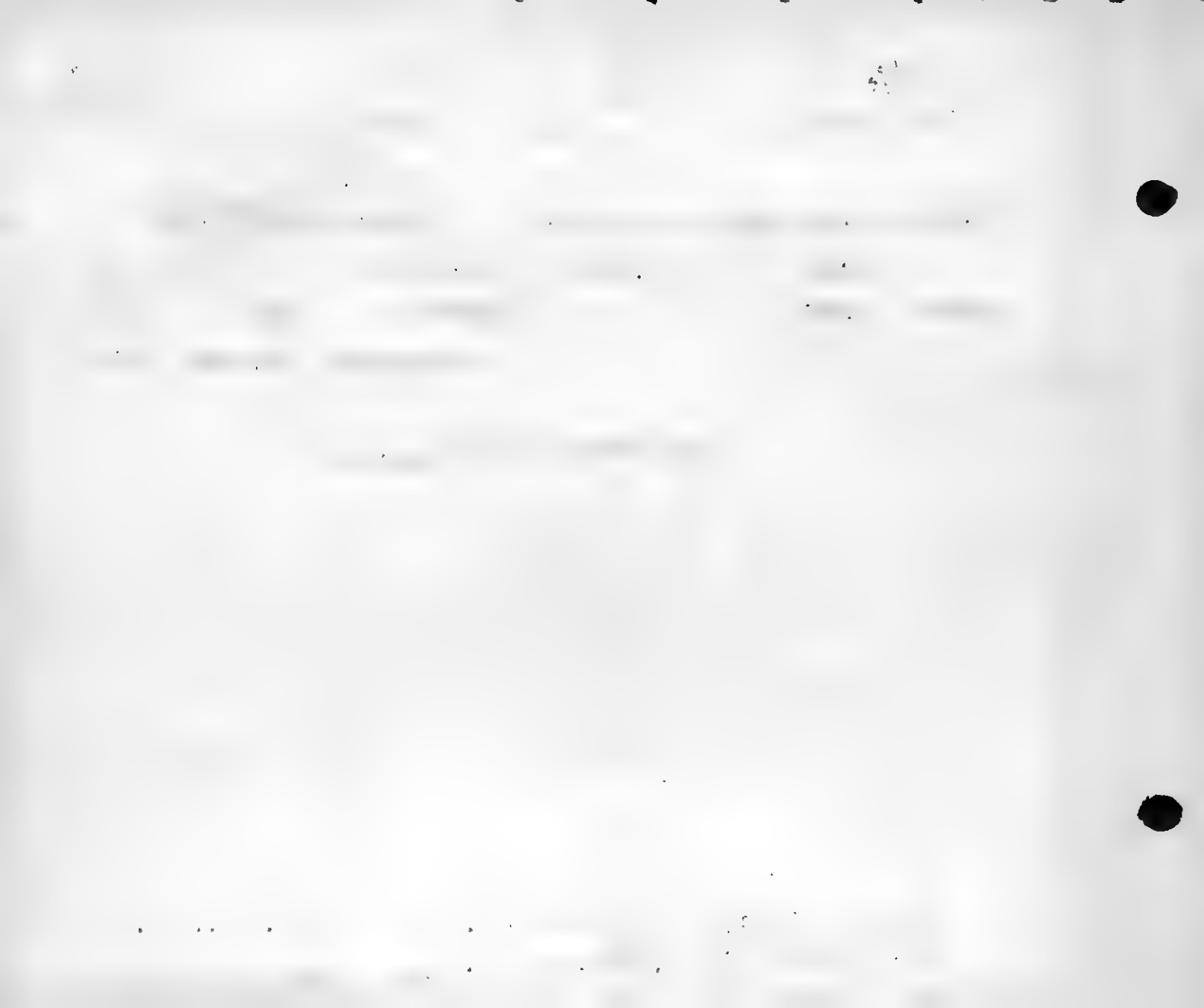


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06710 Items 10, 13, 14 from Co 6 1/23/66 mh					06704				
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MARYLAND</b> c. LENGTH OF STAY IN 1b <b>DUNDALK</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTO. MEDICAL CENTER</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> d. STREET ADDRESS <b>7052 BELCLARE ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year
		<b>CARL</b>	<b>EUGENE</b>	<b>WYANT, JR</b>			<b>5</b>	<b>18</b>	<b>1966</b>
5. SEX	6. COLOR OR RACE	7. MARRIED	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (in years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<b>MALE</b>	<b>CAU.</b>				<b>7/10/92</b>	<b>73</b> yrs.		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Employment</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mfr.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>INDIANAPOLIS INDIANA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Delia Wyant</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address			
<b>NO</b>		<b>213-07-8190</b>		<b>Pt's History</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>26emia</b> <b>163x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>ca of lung, Du/ chondroma of spine</b> b) <b>ca of lung, Du/ chondroma of spine</b> c) <b>ca of lung, Du/ chondroma of spine</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19									
21. I certify that (I) (this hospital) attended the deceased from <b>5-12, 1966</b> , to <b>5-18, 1966</b> , that (I) (we) last saw the deceased alive on <b>5-17, 1966</b> , and that death occurred at <b>12:45</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Lucile A. Torres</b>					22b. DATE SIGNED <b>5-18-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Lucile A. Torres</b>					22d. ADDRESS <b>GREATER BALTIMORE MEDICAL CENTER</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<b>BURIAL</b>		<b>5/20/1966</b>		<b>MORELAND MEM. PARK</b>		<b>BALTO. CO., MD.</b>			
24. FUNERAL DIRECTOR <b>WALTER BROOKS BRADLEY, DUNDALK, MD.</b>					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



06711

## CERTIFICATE OF DEATH

06705

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>119 W. Ridgley Ave.</b>		d. STREET ADDRESS <b>119 W. Ridgley Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Edward</b> First Middle Last <b>Zaiser</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> , Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 19, 1901</b>
9. AGE (In years last birthday) yrs. <b>64</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) <b>Dairy Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick William Zaiser</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth A. ABHAR</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Edward Zaiser, Same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Atherosclerosis General</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5/11/66</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/17/66</b> , 19 <b>66</b> , to <b>5/15</b> , 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>4/17</b> , 19 <b>66</b> , and that death occurred at <b>3:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Bennett A. Stoen</b> M.D.		22b. DATE SIGNED <b>5/16/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Bennett A. Stoen, M.D.</b>		22d. ADDRESS <b>19 W. Seminary Ave. Lutherville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 18, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson</b>		25a. REC'D BY REGISTRAR <b>MAY 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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PLANT INDUSTRY

1913

1913

No. 1		No. 2		No. 3		No. 4		No. 5		No. 6		No. 7		No. 8		No. 9		No. 10		No. 11		No. 12		No. 13		No. 14		No. 15		No. 16		No. 17		No. 18		No. 19		No. 20		No. 21		No. 22		No. 23		No. 24		No. 25		No. 26		No. 27		No. 28		No. 29		No. 30		No. 31		No. 32		No. 33		No. 34		No. 35		No. 36		No. 37		No. 38		No. 39		No. 40		No. 41		No. 42		No. 43		No. 44		No. 45		No. 46		No. 47		No. 48		No. 49		No. 50		No. 51		No. 52		No. 53		No. 54		No. 55		No. 56		No. 57		No. 58		No. 59		No. 60		No. 61		No. 62		No. 63		No. 64		No. 65		No. 66		No. 67		No. 68		No. 69		No. 70		No. 71		No. 72		No. 73		No. 74		No. 75		No. 76		No. 77		No. 78		No. 79		No. 80		No. 81		No. 82		No. 83		No. 84		No. 85		No. 86		No. 87		No. 88		No. 89		No. 90		No. 91		No. 92		No. 93		No. 94		No. 95		No. 96		No. 97		No. 98		No. 99		No. 100		No. 101		No. 102		No. 103		No. 104		No. 105		No. 106		No. 107		No. 108		No. 109		No. 110		No. 111		No. 112		No. 113		No. 114		No. 115		No. 116		No. 117		No. 118		No. 119		No. 120		No. 121		No. 122		No. 123		No. 124		No. 125		No. 126		No. 127		No. 128		No. 129		No. 130		No. 131		No. 132		No. 133		No. 134		No. 135		No. 136		No. 137		No. 138		No. 139		No. 140		No. 141		No. 142		No. 143		No. 144		No. 145		No. 146		No. 147		No. 148		No. 149		No. 150		No. 151		No. 152		No. 153		No. 154		No. 155		No. 156		No. 157		No. 158		No. 159		No. 160		No. 161		No. 162		No. 163		No. 164		No. 165		No. 166		No. 167		No. 168		No. 169		No. 170		No. 171		No. 172		No. 173		No. 174		No. 175		No. 176		No. 177		No. 178		No. 179		No. 180		No. 181		No. 182		No. 183		No. 184		No. 185		No. 186		No. 187		No. 188		No. 189		No. 190		No. 191		No. 192		No. 193		No. 194		No. 195		No. 196		No. 197		No. 198		No. 199		No. 200		No. 201		No. 202		No. 203		No. 204		No. 205		No. 206		No. 207		No. 208		No. 209		No. 210		No. 211		No. 212		No. 213		No. 214		No. 215		No. 216		No. 217		No. 218		No. 219		No. 220		No. 221		No. 222		No. 223		No. 224		No. 225		No. 226		No. 227		No. 228		No. 229		No. 230		No. 231		No. 232		No. 233		No. 234		No. 235		No. 236		No. 237		No. 238		No. 239		No. 240		No. 241		No. 242		No. 243		No. 244		No. 245		No. 246		No. 247		No. 248		No. 249		No. 250		No. 251		No. 252		No. 253		No. 254		No. 255		No. 256		No. 257		No. 258		No. 259		No. 260		No. 261		No. 262		No. 263		No. 264		No. 265		No. 266		No. 267		No. 268		No. 269		No. 270		No. 271		No. 272		No. 273		No. 274		No. 275		No. 276		No. 277		No. 278		No. 279		No. 280		No. 281		No. 282		No. 283		No. 284		No. 285		No. 286		No. 287		No. 288		No. 289		No. 290		No. 291		No. 292		No. 293		No. 294		No. 295		No. 296		No. 297		No. 298		No. 299		No. 300		No. 301		No. 302		No. 303		No. 304		No. 305		No. 306		No. 307		No. 308		No. 309		No. 310		No. 311		No. 312		No. 313		No. 314		No. 315		No. 316		No. 317		No. 318		No. 319		No. 320		No. 321		No. 322		No. 323		No. 324		No. 325		No. 326		No. 327		No. 328		No. 329		No. 330		No. 331		No. 332		No. 333		No. 334		No. 335		No. 336		No. 337		No. 338		No. 339		No. 340		No. 341		No. 342		No. 343		No. 344		No. 345		No. 346		No. 347		No. 348		No. 349		No. 350		No. 351		No. 352		No. 353		No. 354		No. 355		No. 356		No. 357		No. 358		No. 359		No. 360		No. 361		No. 362		No. 363		No. 364		No. 365		No. 366		No. 367		No. 368		No. 369		No. 370		No. 371		No. 372		No. 373		No. 374		No. 375		No. 376		No. 377		No. 378		No. 379		No. 380		No. 381		No. 382		No. 383		No. 384		No. 385		No. 386		No. 387		No. 388		No. 389		No. 390		No. 391		No. 392		No. 393		No. 394		No. 395		No. 396		No. 397		No. 398		No. 399		No. 400		No. 401		No. 402		No. 403		No. 404		No. 405		No. 406		No. 407		No. 408		No. 409		No. 410		No. 411		No. 412		No. 413		No. 414		No. 415		No. 416		No. 417		No. 418		No. 419		No. 420		No. 421		No. 422		No. 423		No. 424	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \_\_\_\_\_ hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

06712		06706	
1. PLACE OF DEATH a. COUNTY <i>BALTO.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>BALTO</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>English Counsel</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>English Counsel 03-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>3504 STEPHAN DOAK RD.</i>		d. STREET ADDRESS <i>3504 STEPHAN DOAK RD.</i>	
3. NAME OF DECEASED (Type or print) First <i>Victoria A.</i> Middle <i>Zillis</i> Last		4. DATE OF DEATH Month <i>5</i> - Day <i>9</i> - Year <i>66</i> 19	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-30-95</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>71</i> yrs.
11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>HATHONG HARECKY</i>		14. MOTHER'S MAIDEN NAME <i>Constancia Spuerkatis</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT <i>Family - Same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lupus erythematosus disseminatus</i> <i>456X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>about 8 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1-10</i> , 19 <i>66</i> , to _____, 19____, that (I) (we) last saw the deceased alive on <i>5-14</i> , 19 <i>66</i> , and that death occurred at <i>4</i> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Florian P. Nadolski</i>		22b. DATE SIGNED <i>5-10-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Florian P. Nadolski</i>		22d. ADDRESS <i>2619 Hammond's Fld Bldg 27 Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>9-17-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Holy Red.</i>	23d. LOCATION (City, town or county) (State) <i>Balto</i>
24. FUNERAL DIRECTOR <i>2614-737</i>		25a. REC'D BY REGISTRAR <i>MAY 11 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>			



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